
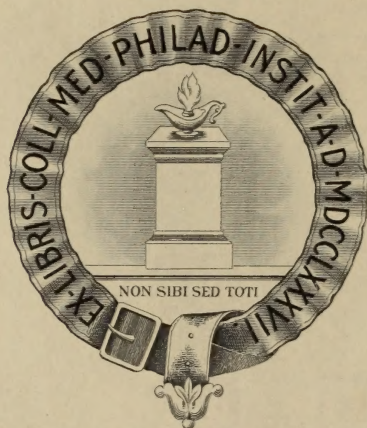




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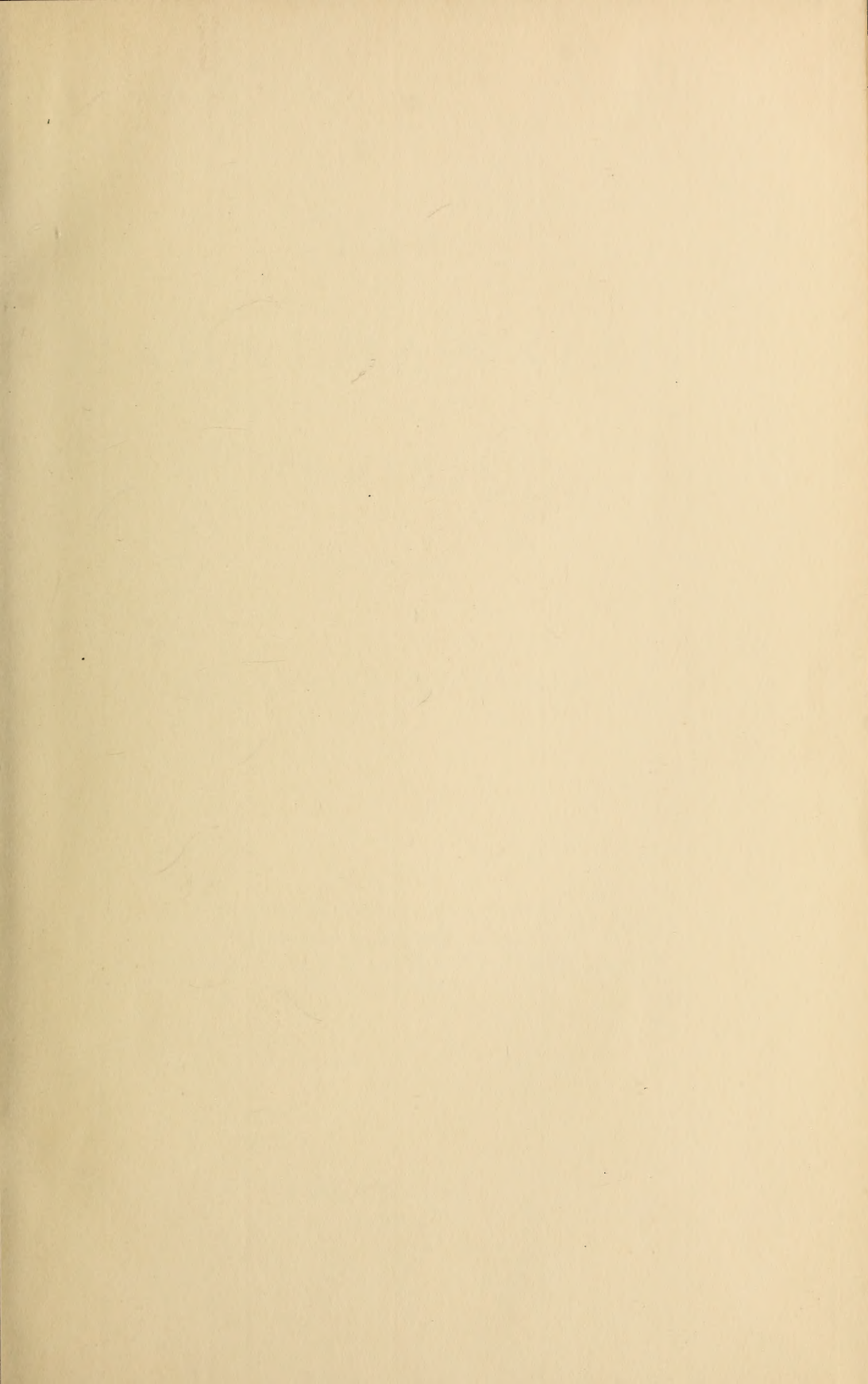




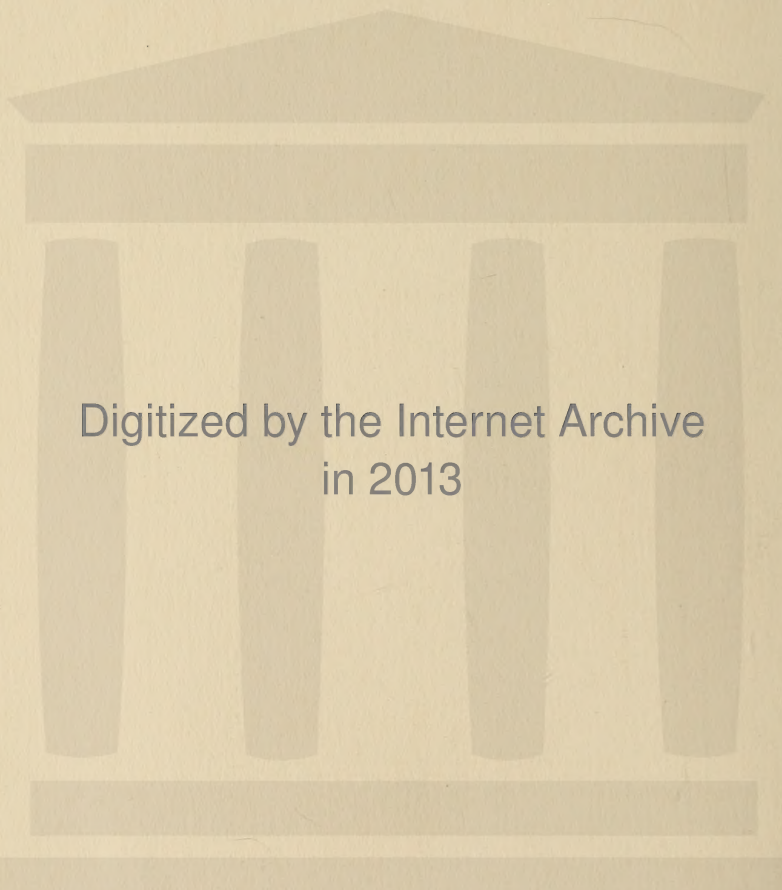












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# The HAHNEMANNIAN Monthly

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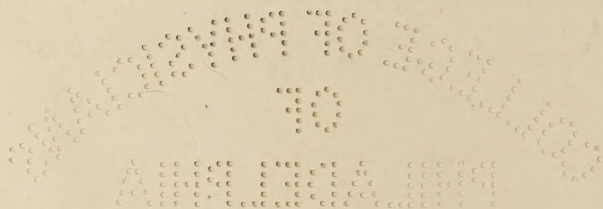
EDITED FOR THE HOMOEOPATHIC MEDICAL SOCIETY BY

CLARENCE BARTLETT, M. D.  
C. SIGMUND RAUE, M. D. and JOHN G. WURTZ, M. D.,  
Editorial Committee

PHILADELPHIA

1920







# THE HAHNEMANNIAN MONTHLY.

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JANUARY, 1920

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## AUTHENTICATION, VALIDATION AND CLINICAL VERIFICATION OF THE HOMŒOPATHIC SYMPTOM—A PRACTICAL SUGGESTION AND A WARNING.

BY

THE LATE WILLIAM A. SEIBERT, M.D., EASTON, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 18, 1919.)

RECENT college events and disasters, editorial writings, and the excellent paper on "Modernizing Homœopathy," by our Dr. Bartlett are to blame for this paper. How can one's homœopathic blood keep from boiling as we see our "birth-right being sold for a mess of pottage" by a group of quitters. Dr. Bartlett's paper was undoubtedly similarly inspired, and I wish to supplement briefly what he says. I don't like his title, however, for homœopathy will not be "modernized." It is ultra-modern now. Moreover, the criticisms and complaints from all sources seem invariably to be aimed at the homœopathic materia medica—its voluminousness, and the authenticity and reliability of the symptoms rather than at homœopathy.\* The *bête noire* of the homœopathic physician, and wherein lies our one deficiency, is, therefore, our materia medica. The irony of this fact is impressive, for the homœopathic materia medica pura is composed only of symptoms observed in the healthy human subject on exhibiting a drug in proving, and a record of these symptoms is a purely scientific procedure, if there ever was one, and it can never be effaced. The logical

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\*Dr. Bartlett accepts this criticism of his friend, Dr. Seibert, as a point well taken.—Eds.

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need, therefore, surpassing all other demands upon homœopathic physicians, is to establish a satisfactory authentication of a symptom, and then to validate it fully as possible and finally to clinically verify it. This properly done lays the foundation for all the classifying and analyzing that the "acid test" of science could demand.

A practical remedy for this state of affairs has not, to my knowledge, been suggested. To reprove (*sic*) the remedies or prove new ones, to develop pharmacology more and more, to publish more literally facts as discovered in practice or even to multiply the clinical verification of the homœopathic remedies in therapeutics; all will fail when applied separately, and this has been demonstrated, but when all are applied conjointly to a symptom of a remedy, the proof of the scientific status of that symptom becomes established beyond peradventure.

By "homœopathic symptom" I mean any symptom in the homœopathic materia medica. Its authentication—as done by T. F. Allen in part, its validation—as done by the reprovers and laboratory workers in physiology and pathology, and its clinical verification—as now promised to be carried on in our hospitals and dispensaries in a more systematic and scientific manner, are the "acid tests" for the separation of the wheat from the chaff of our materia medica, and the homœopathic symptom must be subjected to all of them before its scientific status can be determined.

I have "harped" upon this subject, argumentatively as well as descriptively, during the past dozen or more years with numerous papers read before various societies and reprinted in various medical journals. It is not my purpose to "rehash" all this matter, but here wish again to emphasize the fact that I would not amend what I have claimed in these papers. On the contrary, I am more convinced than ever of the correctness of the claim—authentication of the homœopathic symptom is the most important work before homœopathy to-day, and the research laboratory should bear this responsibility. To begin with, it may not appeal to laboratory workers because it entails so much clerical work. The provers and the reprovers cannot revel in their favorite occupation exclusively, although they get nowhere, as evidenced by the wonderful "Test Drug-Proving of Belladonna," by the O. O. & L. Society which has not added to our knowledge nor practical applicability of belladonna; nor have the newly proved remedies done much

more than add to the vastness of the confusion. The suggestion of validating the symptom may not appeal to the enthusiastic clinical verifier who, it appears to us, is a slave to a voluminous *materia medica* on faith. On the other hand, as Dr. Bartlett says, "Unless the clinical confirm the laboratory, the latter is useless."

My practical suggestion is a card or loose-leaf for each symptom of a remedy selected as sufficiently studied and developed for the "acid test."

On this card should be put the symptom first, then its first author and succeeding ones as well, establishing its authenticity and possibly incidentally suggesting a revision of the monumental work of T. F. Allen.

Next on the card should be put a discussion of the grammatical accuracy of the language of the symptom, and definitions and comparisons, if necessary, so that all possibility of ambiguities be eliminated.

Next should be added any additional information regarding the symptom as acquired by reproving. Reproving is of great value not only as authenticating the symptom, but for the lasting impression the evolvment of symptoms is apt to make on the mind of the reprover. It may also incidentally convince, as it did Hering himself, that "almost intuitive perception had guided Hahnemann in his work." Hering also avers that "after nearly three-fourths of a century of daily searching scrutiny, Hahnemann's original works must be accepted as bearing the imprint of being wrought by a master mind." How can one help pitying, therefore, the so-called modern scientists who would reprove to replace supposed incorrectness or unreliability of Hahnemann's original works? However, Hahnemann's *materia medica pura* symptoms, as well as any and all others, must withstand the application of any "acid test," and even the Rockefeller Institute—if they dared investigate as they could and should, like in the case of Hering himself, would be apt to be converted to support the true findings.

Next on the card should be placed any laboratory findings regarding the symptom. These physiologico-pathological verifications are essential for acquiring a knowledge of the remedy's action, and though they may not constitute the most valuable symptoms for the selection of the *similimum*, yet they surely validate the symptom and may clear up the why and



wherefore of a prescription, doing away with the blind matching of symptom method, that will not withstand the "acid test" of science.

Then the clinical verification should be noted and authenticated, and it is here we would add the word of warning. It will be necessary on each and every occasion to specify all the symptoms on the strength of which the verification of the remedy is recorded. Simply certifying the apparent value of a remedy in a certain disease, without registering more than that fact or the reasons for this conclusion, is not satisfying even to homœopathy, and will not be accepted as a scientific "acid test." A symptom found in the proving of a remedy, repeatedly disappearing upon the exhibition of said remedy to that symptom in diseased conditions, will be accepted as a real clinical verification. Therefore, verify the symptoms of a remedy rather than the remedy itself, and record the comitants that helped to decide for the particular remedy.

The homœopathic symptom, thus authenticated, validated and clinically verified—each on its own card—is now ready for any further analysis and classification that scientific sticklers could demand. The wheat can readily be separated from the chaff by so grouping them; but you will observe Hering suggested to remove the wheat from the chaff and not the chaff from the wheat, for much wheat will still be garnered from the chaff as symptom after symptom becomes amply verified.

With this arrangement of symptom on card as a basis, those who want only to take account of those physiologico-pathologically validated may as easily have such a *materia medica* as the homœopathist who wants no symptoms in his repertory of the symptomatology of that remedy sacrificed. It will be easily possible to compile a 100 per cent. accurate symptomatology of that remedy for those who want that. From these cards can be extracted any general or special analysis of the drug desired. The modalities of the various rubrics of the remedy, as well as many other classifications and analyses of the remedy, can evidently and more or less easily be framed.

In conclusion, there is one all important factor not to be ignored. As popular as was the "fox trot" or "bunny hug" is the "homœopathic balk," and it seems most durable. The volume of the work produces what in the parlance of the street is called "cold feet," and there, up to this time the furtherance of

the work has been halted. The difficulties to be overcome are great but not insurmountable, and the voluminous material not unmanageable. Taken the much-proven belladonna as an example, probably 3,000 cards would be required, but that with a proper co-operation and division of labor is not any more staggering than much other work that has been undertaken by the research laboratories.

The work suggested in this paper seems to be about the last straw left for the homœopath to hang to. Again in street parlance, if we do not "get busy" the old school will, under a different name appropriate even this—"not yet but soon."

#### DISCUSSION.

DR. AUG. KORNDORFER, Philadelphia: Fifty odd years ago, as I sat under Dr. Hering, studying *materia medica*, a favorite remark of his was, "Gentlemen, I came to teach you *materia medica*; I can only show you how to study *materia medica*." That holds just as true to-day as the first day that I heard him utter it. One of the great difficulties that we have had during the past couple of decades, a difficulty that, I am glad to say, is now being overcome, and, I trust, will soon be entirely overcome, has been the neglect of a careful study of the symptomatology as given by Hahnemann and other reliable provers. I have no objection to the reproving of drugs; but if they have been proved by Hahnemann, I am sure that it will be found to be, as was shown in the O. & O. Society's results with belladonna, labor spent for naught, with the exception of the fact that it has confirmed the belief of those who did believe in the original provings so thoroughly that they cannot doubt them any more, and has led others to believe the provings of Hahnemann without the necessity of going through a reproving to confirm their original faith. Our homœopathic *materia medica* will ultimately be placed on an absolute scientific basis. The method suggested by Dr. Seibert in his paper would afford such a verification of each symptom that there would be no doubt as to the mode of application of these remedies under the law of similars. It would be a tremendous task, but what would be too great an effort in so noble a work? What would not be the willingness of those at work in it to devote time, thought and money for the purpose of developing it for the salvation of the world depends on the ultimate recognition of the scope of the law of similars? Had the old school profession accepted the law of similars at the time Hering first developed it for our use, what would not have been the prog-



ress in medicine to-day? When anthracinum and other remedies of that type were introduced by Hering, if they had been generally adopted, much greater progress would have been made. Think of the wonderful results produced by anthracin in the sheep of Italy. In higher potencies, it cured not only the sheep, but also many shepherds who were attacked by anthrax while tending their sheep. It was the similimum to that epidemic, and it became the similimum to other pathologic conditions that occurred in other forms of disease.

We can go through these remedies, considering what we can offer to the profession. I remember the time when it was said that we should be hanged for offering such things to the sick; that we were, in reality, murderers, and were willing to sacrifice the life of a patient for an experiment. That was the position that we were in thirty or thirty-five years ago. Since then, the light has come to the Old School. They have accepted the idea that the law of similars is effective; that the minimum dose is not only useful, but essential. One of them wrote me, last January a year ago, that he was using tuberculin in doses of 1,100,000 of a milligram, no oftener than once in three days, and preferably once in seven days. How many of you habitually practice in such small doses? That was an allopath who, some years ago, declared that homœopathy was a fraud; yet he is using doses that would have been considered irrational to use some years ago. One man, sitting near me, said that he wished that he had my faith. Let him have it. The thing is sure to come. Homœopathy will be acknowledged as the true system of practice of therapeutics.

DR. J. WILMER STRONG, Philadelphia: I think that the time will come when we shall know more about the subdivision of matter. Great strides have been made in the last few years. A cable across the ocean was considered a great thing once; and then, if anyone had said, "I will talk to some one in mid-ocean without using a wire," he would have been thought a fit subject for an insane asylum. I look for the time to come when we shall astonish the world in regard to the subdivision of matter.

**HYPERTROPHIC PYLORIC STENOSIS IN INFANTS.**

BY

C. SIGMUND RAUE, M.D., PHILADELPHIA.

Professor of Paediatrics in the Hahnemann Medical College of Philadelphia.

(Read before the Homœopathic Medical Society of Pennsylvania, Philadelphia, September 16, 1919.)

PYLORIC STENOSIS occurs in infancy as a result of a congenital hypertrophy of the musculature of the pylorus. The stenosis is progressive in development and results in complete obstruction of the pylorus. The circular muscular fibres are mainly involved; other pathological changes are wanting. Muscular spasm, no doubt, plays a part in the production of the pyloric obstruction and cases of pylorospasm unaccompanied by a hyperplastic tumor involving the pyloric muscle are by no means rare and must always be taken into consideration when the question of hypertrophic pyloric stenosis is under discussion. However, the theory that long-continued pylorospasm can induce hypertrophy of the pyloric muscle to the degree which we see in typical cases of hypertrophic stenosis is untenable in the light of our present knowledge.

Pyloric stenosis is more frequently encountered in male than in female infants. It has no connection whatsoever with dyspepsia or improper feeding; indeed the majority of cases appear to develop in breast-fed infants. The etiology is unknown; a family predisposition is noted in some cases. Two of my cases occurred in the same family. The condition is a congenital malformation probably atavistic in type.

Vomiting is the chief symptom although it is not present at birth. The babe is usually well developed and well nourished at birth, nursing and gaining normally for a time. Vomiting comes on more or less abruptly toward the end of the first month and gradually increases in severity and in persistency so that the child loses weight rapidly and the bowels become obstinately constipated. Enemata bring away bile-stained mucus but no milk residue. The food is naturally suspected of disagreeing with the infant but no dietetic treatment exerts any influence upon the vomiting which now occurs practically after every feeding and becomes projectile in type. Sometimes one feeding is retained but after the next feeding the combined



amount of both is vomited. Vomiting is not accompanied by nausea or pain. The babe may vomit toward the end of a nursing and then eagerly seeks the nipple and nurses all over again.

Dilatation of the stomach gradually takes place and later on it may hypertrophy. The epigastric region is prominent, especially after nursing, while the lower abdomen is sunken and flaccid. The intestinal tract is practically empty. When the stomach is filled, peristaltic waves make their appearance due to the abnormal effort of the stomach to empty itself. These waves originate in the left hypochondriac region and cross the epigastrium to the region of the pylorus where they cease. The outline of the stomach is plainly indicated by these waves and we can observe from day to day the increasing gastric area.

At this stage a small oval tumor about the size of a small olive can be demonstrated in the pyloric region in the majority of cases. The usual site is to the right of the median line, midway between the tip of the xiphoid and the umbilicus. It is most readily felt just after vomiting, at which time the abdomen is relaxed.

Residual food is usually present in the stomach and this is a most important diagnostic sign. By inserting a No. 16 French soft rubber catheter into the stomach four hours after a feeding, an ounce or two of residual food can be aspirated, providing there has been no previous vomiting. The X-ray also shows the opaque meal still in the stomach and the cap and duodenum empty.

The prognosis and ultimate outcome of cases of pyloric stenosis depend upon the degree of anatomical changes present in the pyloric region of the stomach and whether the symptoms are predominately mechanical or spasmodic in character. Owing to the difficulty of sharply differentiating hypertrophic stenosis from pylorospasm, confusion as to the prognosis naturally arises. Undoubtedly many cases of spasmodic pyloric stenosis have been taken for hypertrophic stenosis; or, a case of hypertrophic stenosis may at times present more spasm than actual anatomic obstruction and so recover under medical treatment. Cases, however, which show an absolutely unyielding obstruction at the pylorus and in which a tumor can be distinctly felt, do not yield to any but surgical treatment. Anyone who has seen the hard cartilaginous mass

surrounding and constricting the pylorus, demonstrated on the operating table or at autopsy, will be convinced of the futility of trying to treat such a case medically.

The diagnosis of pyloric stenosis rests upon the history, the persistent projectile vomiting, the gastric dilatation with visible epigastric waves and the progressive rapid emaciation of the infant. The first symptom is vomiting, setting in abruptly in an infant from two to four weeks old without assignable cause. Associated with the vomiting is obstinate constipation and scanty urine and loss of weight. There is no evidence of nausea or pain and dietetic treatment does not influence the vomiting.

Pylorospasm is differentiated by the irregularity in the character of the vomiting, the fact that food still passes into the intestines as shown both by the character of the stools and by the X-ray plates. A tumor can at times be felt in spasmodic cases due to spastic contraction of the pylorus, but this disappears after vomiting or after gastric lavage. Furthermore, medical and dietetic treatment bring results which are not seen in hypertrophic stenosis.

TREATMENT.—The early treatment of the vomiting is that of dyspeptic vomiting. Milk should be discontinued for a time, and whey, barley-water, and albumin-water may be tried. Lavage should be systematically carried out. The stomach should be thoroughly washed out twice daily with a warm solution of bicarbonate of soda, drachm one to the pint, for the purpose of removing all food residue and to wash out the gastric mucus. The child should be fed at four hour intervals and heat applied to the epigastrium after each feeding. The child should be placed on its right side with the head slightly elevated. Breast milk may be cautiously tried next. Should the vomiting persist in spite of these measures and the child continue to lose weight, the question of surgical interference must seriously engage our attention.

As soon as we are convinced that the case is one of hypertrophic stenosis with complete anatomical obstruction, it is our duty to advise operation and not wait until the child has become so weak and emaciated that it is no longer a good surgical risk. Cases with well defined gastric peristalsis, a palpable tumor and complete retention as shown by the X-ray plates and gastric lavage, come under this category. When, however, there is still doubt as to the completeness of the ob-



struction and the child is not rapidly getting worse, we may try the effect of the thick farina feeding as proposed by Sauer of Chicago and successfully used by him in a number of cases. Sauer reaches the conclusion that the thick immobile cereal cannot be ejected from the stomach by the sudden explosive contractions that produces vomiting of the milk feedings and, therefore, is held in the stomach long enough to eventually find its way into the duodenum. He has shown by X-ray plates that the patency of the pylorus is much greater after the thick cereal feedings than after milk-mixture feedings.

The operation of choice is Rammstedt's pyloroplasty. The technique is simple but the operation is a delicate one and requires care and skill. Gastro-enterostomy has been abandoned by the majority of surgeons who have had much experience with these cases. The technique presents many difficulties, the surgical shock is great and the mortality is high. My experience has been very discouraging with this operation. I have seen many cases operated by our very best surgeons. The results have been uniformly poor. I can understand why many pediatricists still cling to the medical treatment of pylorus stenosis considering the small chances of recovery under gastro-enterostomy. With the Rammstedt operation, however, the surgical risk is small. The operation is of short duration and not accompanied by shock. The results are brilliant; vomiting usually ceases at once and so far there has been no return of the stenosis in any of my cases.

#### DISCUSSION.

DR. JOHN E. JAMES, JR., Philadelphia: Needless to say, this paper by Dr. Raue is an exceedingly timely one; I cannot help feeling that many of these cases we have failed to recognize in the past, and, in consequence, many have died because proper surgical cure was not instituted. At this moment, it remains for me merely to bring into mental juxtaposition the anatomical defect—hypertrophic pyloric stenosis—and the modern surgical intervention—partial pyloroplasty according to the method of Rammstedt.

Gastro-enterostomy, as long since practiced, is to-day looked upon as an obsolete procedure. Considering the time required for this operation and the physical condition of the child when first seen by the surgeon, it is not to be wondered the mortality was exceeding high. The Rammstedt procedure

offers celerity in operation, simplicity in technique and decidedly lowered mortality rate.

Partial pyloroplasty is not something new. In 1916 Downs, of New York, published statistics of some 66 cases of hypertrophic pyloric stenosis operated upon by him according to this method. In the first series of 31 cases the classical Rammstedt procedure was modified by incision in the stomach through which a small probe was passed into the pylorus to determine how far to cut through the hypertrophic ring without injury to the delicate mucosa. In this series there was a mortality rate of 32 per cent. Several fatalities were attributed to the modification in technique. In the second series of 35 cases operated without the modification the mortality was about 21 per cent. A subsequent series of cases by the same surgeon serves to emphasize the splendid results obtained by the unmodified Rammstedt operation.

The technique is comparatively simple. Under general anaesthesia the abdomen is opened so as to readily allow the delivery of the pyloric tumor. An incision is made along the upper face of the tumor in the direction of its long axis and by blunt dissection the muscular layers are divided until the delicate mucosa begins to pour into the wound. There is no bleeding; there should be no attempts to cover the raw surfaces of the pyloric tumor mass by flap-splitting or transplants. The stomach is dropped back into the abdomen and the abdominal wound closed.

A warning should be given as to an apparent constriction observed at the junction of pylorus and duodenum following the supposed complete separation of the hypertrophic tumor mass. In three or four cases we felt that this band should be relieved with the result of a small puncture wound being made into the duodenum sufficiently large to permit some bubbling of gas. In each case the opening was closed and uneventful recovery obtained. It is our endeavor, now, to be quite conservative at this junction, relying upon the splitting of the pyloric tumor proper for good results.

Inasmuch as we have had no fatalities in our limited number of cases to date, it is our very strong conviction that the unmodified Rammstedt operation offers a brilliant chance of a cure in these cases in which other operative procedures have rather uniformly offered an exceedingly high mortality rate.



**EARLY RECOGNITION OF MENTAL DEFECTIVES.**

BY

ALBERT ROWLAND GARNER, M.D., NORRISTOWN, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, September 16, 1919.)

DESCARTES said, "That if it be possible to perfect mankind, the means of doing it will be found in the medical sciences." The students of pedagogy, psychology, sociology, biology and law are all interested in mental defects, but the active interest of the medical profession is absolutely required. There are over fifteen thousand recognized mental defectives in the State of Pennsylvania. This number includes only those who are in institutions. They require supervision because they cannot take care of themselves and are a menace to society. It is evident that this number does not by any means include all the defectives from whom society could be protected. That fifteen out of every one thousand school children are mental defectives, is but a conservative estimate.

The chief cause of primary amentia is neuropathic inheritance. Feeble-mindedness may be transmitted from ancestors who have mental weakness, insanity, syphilis, epilepsy, alcoholism and tuberculosis. (1) "More than half a century ago records were published proving that poisons, such as lead, mercury, alcohol, malaria, smallpox or tubercles in concentrated doses are possible causes of mental defects in the children." (2) "Dr. Beard contends in his study of the morphological continuity of germ cells as the basis of hereditary and variation, that food, climate, toxins, diseases, natural phenomena of all kinds can affect the corresponding characters of any germ cell." Thus we can see that the environment of parents may produce a variation from the normal line in their offspring.

Maternal ill health, shock or accident may so affect the germ plasm that cell deterioration will result.

A certain percentage of causes of amentia may happen at birth, such as injury to the brain from prolonged labor or forceps. (3) "Dr. Langdon Down estimated the frequency of the latter condition at 20 per cent. and 40 per cent. amongst those who were first born." Premature births was noticed as a factor in a small percentage of cases by Dr. Shuttleworth.

Then, too, there are causes which come after birth. Doubtless, traumatism, that is, actual brain injury, hydrocephalus and severe infectious fevers with associated meningitis might also cause mental decay. Convulsions in childhood, malnutrition, epilepsy and shock or fright, in my opinion, could only be contributory causes influencing the already hereditarily unstable nervous system.

Unusual care should be used in making a diagnosis, because when once a child is branded feeble-minded, he or she remains feeble-minded forever in the opinion of friends and neighbors, no matter whether the diagnosis was correct or not, or whether the child gets well or not. At the time of observation or examination all possible circumstances must be considered in connection with the child's environment; the subject must understand the language and expressions of the examiner and it is equally important that the examiner should understand the language and expressions of the subject. We are all familiar with most of the symptoms that the child who enters this life burdened with a pernicious heredity would display.

It is not necessary to enumerate the long list of symptoms of feeble-mindedness, such as a microcephalic or asymmetrical head, irregularly shaped and mislocated ears, with or without the Darwinian tubercles, prognathic or dropped jaws, staring and crossed eyes, small stature with deformities, blank expression with apparent sullenness, and so on. They would be too numerous to mention and would be telling you nothing that you do not already know.

It, however, does appear to me that emphasis should be placed on the totality of the symptoms with the ancestry as a known positive background before a diagnosis is made. Binet and Simon tests also help ascertain the mental status.

Dulness and apparent stupidity do not necessarily mean feeble-mindedness. Children vary in the manner in which they form their concepts. Some children form visual concepts readily with slow auditory concepts and other children may form auditory or tactual concepts readily and the visual slowly. It is a well-known fact that some of our greatest writers and scientists have been considered dullards in their childhood: Robert Fulton, Alexander von Humboldt, George Eliot, Oliver Goldsmith, Henry Ward Beecher and John Hunter are



only a few of the large number of great men and women who were stupid in their childhood.

It is necessary to discriminate between those who are apparently dull and yet really have normal or even brilliant futures and those who will be permanently mentally deficient.

You can readily see the importance of early recognition of a mentally afflicted child. In the first place the removal of a feeble-minded child from the association of normal children is a service of untold benefit to the normal child. A defective in the public school room means that the teacher wastes her energy and spirit on a subject on which she can make no impression and this robs the teacher's vitality and normal children of her best efforts.

A feeble-minded child may contaminate a whole school with his absence of principles and with his vicious habits.

A mental defective in the wrong place is an economic loss or waste. He is an unnecessary expense and care, but in the proper environment he may be trained not only to support himself but become actually productive.

An "ament" not in an institution is a vampire in the family. He is depressing to the community and demoralizing to the children with whom he is associated, whereas in suitable environment, as he becomes useful on account of his training, he is turned from a fretful, perhaps malicious, indolent child to a contented and happy one.

The dangers to society, that I have just mentioned, of mental defectives are slight compared with the great menace that comes from this class. However lacking in development are the minds and organs of this class the sexual organs are always super-normal. With the exception of the very lowest grades which form but a small percentage, there is absolutely no deviation from this rule. Such being the case, procreation takes place accordingly. The breeding of mental defectives goes on much faster than the breeding of normal human beings. Dr. Goddard and many other scientists agree with the Mendelian theory. The deduction is obvious. The breeding of mental defectives must be stopped if the normal wholesome minded part of the race is to predominate.

Asexulization has an economic advantage over segregation and it is much more sure.

We, as physicians, have the opportunities to use the special duties and privileges that belong to our vocation, to

help the race to a higher level of mentality. May we not be misguided by false charity nor blinded by unscientific sentimentalists but throw the weight of our influence for what it is worth into the scale of evolution and help bring about—who knows—the genuine superman.

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### HYGIENE AND SANITATION.

Address delivered before the Homœopathic Medical Society of Pennsylvania,  
Bureau on Sanitary Science, September 18, 1919.

BY

THOMAS W. JACKSON, M.D., ASSISTANT TO THE COMMISSIONER  
OF HEALTH OF PENNSYLVANIA.

I AM not unmindful of the distinction conferred by appearing before this important and influential society as the representative of the distinguished Commissioner of Health of the great Commonwealth of Pennsylvania, of which Commonwealth you and I and all of us are part.

Preventive medicine knows no denominational or sectarian separations. The State Department of Health desires that every legal practitioner of medicine in Pennsylvania shall consider himself a part of our disease-preventing machine. It desires from you, as its agents, loyal support and assistance quite as much as conformance with the law in rendering reports; it desires your constant assistance in many ways and asks of you that you promulgate throughout your various communities the true aims and purposes of the department.

We sometimes even wonder whether all of our physicians realize these purposes and occasionally we have evidence of reactionary influence at work in the community. Recently at a particularly enthusiastic meeting of the various women's betterment agencies of a county, met to formulate plans for assisting in the public health work of the State in that particular county, a woman presented an informal protest from some of the men of her family and community, including at least one minister, against the intrusion of the State Health Department in asking for medical inspection of schools and community follow-up work in the homes of school children. The



resentment seemed to be closely linked with a fear that the women would not be paid for the social service rendered! Surely this is the profiteering spirit gone mad.

Fortunately these outcroppings of selfishness and ignorance are infrequent but they serve to indicate that the duties, privileges and obligations of the individual citizen in protecting the public health and in bettering the social fabric are not universally appreciated as yet; and that benighted souls with sordid ideas exist in the most forward-looking communities. It is probably not worth while to point out to such individuals that the purpose which actuates the physician in preventive medicine actually impairs his financial income and involves the highest form of self-sacrifice.

To you men—many of whom have so recently stood, shoulder to shoulder, facing the common national enemy; looking after the public health of the soldiery as well as binding up their wounds; at the cost of sacrifice, financial and personal, unequalled in any of the other professions—sordid considerations cannot appeal.

There is needful, therefore, only a clarification of the purposes of the State Department of Health. These purposes have been announced to the public from time to time and will be so announced hereafter and we trust that they are familiar to you. Whenever the department policy and purpose is not clearly understood inquiry is invited and explanation is promised. The new health department administration of Harrisburg is now well launched on its program and desires the support and sympathy of every citizen. The warfare against disease and disease-producing conditions is perpetual. It will never be finished. There is no permanence of corrected conditions unless effort be constant and continuous.

Then, too, the impossible must not be expected. Our limitations must be admitted. Our abilities to combat communicable diseases are not equally effective.

For example: Of the infections, the filth diseases—largely acquired by ingestion—are both theoretically and practically preventable; so, too, are the parasitic and insect-borne diseases.

Most baffling of all are the infectious respiratory diseases, a large and important group, which prevail endemically and epidemically—and here we must temporarily admit failure of control. I say temporarily, for no one doubts the ultimate con-

quest of these death-dealing diseases. We must, however, concentrate our effort upon this problem, avoiding the spectacular and declining to accept the unproven claims of the faddist, whether they relate to methods of communicability or cure.

Without entering into a discussion of the subject, a few facts, related to prevention, may well be emphasized here.

1. Individual isolation is an efficient protection.

2. Experience has shown that ventilation alone is far from being an effective safeguard, and whatever the value of fresh air may be from the therapeutic standpoint, ventilation alone must not be depended upon to prevent the spread of the infectious respiratory diseases.

3. Spray infection through the mucous droplet, projected into the air and—far more important—received fresh and teeming with living bacteria directly upon the nasal, conjunctival and buccal mucous membrane of another, through speech, cough, sneeze, song or other vocal effort, usually in crowds or groups of people, is by far the most fruitful method of communicating influenza.

The indirect contact method, in spite of certain illustrated and highly colored newspaper stories based on articles which have appeared in public health journals, is not to be compared to the direct transfer method.

4. Any mechanical obstacle which intercepts the flight of droplets, such as a mask placed upon the patient, is useful in whatever degree it really intercepts the droplet.

5. In all diseases propagated by spray or droplet infection, efficient surface disinfection is called for and this means knowledge and technique on the part of the physician, nurse or public health agent who performs it. The methods described in a pamphlet by the State Department of Health and known as "Sanitary Cleaning" are considered adequate and effective if performed with thoroughness. Fumigation as ordinarily carried out is useless.

Out of recent experience and observation has arisen the realization that certain diseases hitherto considered unrelated are akin in the manner of their acquisition.

A few years ago we would hardly have considered measles as a respiratory disease, as a disease of adults or indeed as a serious malady, but today there is general acceptance of the fact that it is primarily a respiratory infection and that its com-



plications, nearly all of them respiratory complications, give rise to a heavy mortality.

It would not have occurred to us that cerebro-spinal meningitis is primarily a respiratory infection, or that mumps, diphtheria, the primary pneumonias, influenza, tuberculosis and scarlet fever may be grouped together. Yet upon a moment's consideration it will be evident that these diseases and others are all acquired through the gateways leading to the upper respiratory tracts. This realization gives us an important clue to prevention, a clue which you must individually follow up, however.

I confess that I am tempted to enter into detail but the recognition of the fundamental principles is far more important to us all and I, therefore, ask you to apply close scrutiny to the popular public health educational articles which appear from time to time, separating the wheat of truth from the chaff of untruth or half truth. Far too much positive misinformation of the public escapes contradiction today.

Far be it from me to decry popular education in disease prevention, but let us see to it that such education be based on fundamental principles and most of all that the teaching be truthful. It is far easier to spin attractive theories and make extravagant claims beyond the possibility of performance than it is to pursue a sane, conservative, forward-looking program which takes due account of scientific limitations and the popular disposition to measure and regulate all effort and expenditure by promise of gain.

It is not pleasant, perhaps, to admit that economic interest is a greater urge to public health endeavor than is philanthropy but it is a fact that must be faced and fortunately most details of the public health program, if not all of them, may be justified from an economic viewpoint and our motives may well remain both philanthropic and economic.

You know that the State Department of Health is divided into numerous divisions, each with a special sphere of activity, and headed by a specialist in that activity. These divisions do not function independently but are co-ordinated with a single main object—the public betterment—in view. Thus epidemic control and laboratory investigation, child welfare, tuberculosis control, venereal disease control, public health education, sanitary engineering with pure water supply, the proper disposal of wastes and improved housing as its objects, the

collection of vital statistics, the control of habit-forming drugs, school hygiene, the distribution of antitoxins and biological preparations and public health nursing are all co-ordinately administered by the central organization at Harrisburg and with a single end in view.

Even to enumerate the activities of these various divisions would be an undertaking too large for this occasion. I can only assure you that the governing principles of the commissioner and his advisors are: (1) The largest economy consistent with the most far-reaching results; (2) As little interference with local self-government as is consistent with the enforcement of the State laws; (3) An impartial enforcement of the law everywhere.

There should be a general recognition of the fact that communities are expected to govern themselves and to pass and enforce additional health ordinances; as well as to enforce the State health laws and that this obligation must remain local and may not be passed on to the State Department of Health.

I might perhaps mention the sphere of the epidemiologist, for every one of you who investigates a local outbreak of communicable disease in his clientele or family practice is in some degree an epidemiologist. In the public service the well equipped epidemiologist must be something of the clinician, statistician, pathologist, bacteriologist, climatologist, lawyer, public health instructor, general hand-shaker and sympathetic citizen.

His life is one of vicissitude and taken altogether it is not always a happy one. He accumulates some friends but rather more enemies and is often an object of suspicion. He can never count on popular or even professional approval of his work and he must account as his sole reward the realization of work painstakingly and conscientiously done. His mistakes follow him about like an ever-fattening Nemesis and from the similarity of the term "epidemiologist" he is constantly mistaken for a specialist on epididymitis or an authority on demonology.

Yet there is constant variety in the life of the epidemiologist. No two outbreaks of disease are identical in all respects. Ofttimes the qualities of a detective—(analytic and synthetic)—are needful to establish the truth, while in other cases the facts need but to be assembled for one to deduce the obvious conclusion.

Where laboratory diagnosis is involved local laboratory facilities should be employed if they be at hand, supplemented



by confirmations by the laboratory of the State Department of Health in Philadelphia. It is hoped that a portable traveling laboratory will be available in the department before long, in which event the necessary investigations, bacteriologic or chemical—or even autopsy investigations—can be made immediately and upon the spot.

Laboratory aid is not always required, however. Often the answer to the problem is readily obtained by the application of simple common sense.

The public state of mind in communities excited by sensational newspaper stories is often such as to cause a delay of application of the common sense test until local fears are calmed by assurances from the visiting investigator. This applies to the lay public and in somewhat less degree to the local medical public. The average practitioner sees the cases in his own clientele and knows little of those of his professional brethren, unless he chances to see them in consultation. A visiting investigator with the *entre* to all households and the authority of the State behind him has a distinct advantage over the local practitioner.

I might perhaps tell you something of interest concerning the health legislation of 1919, but there is now in process of printing a pamphlet which will recite this legislation and which will present the new laws as passed. This publication will be available to all, and it is hoped that you will send requests for copies to us. The bulletin will be ready for distribution within the coming month.

Let me speak of the third-class cities from which some of you come. Every community has special disadvantages of its own. If the community be an old and prosperous one these conditions are apt to be those of reaction and stinginess, begotten of selfishness.

In new towns rapid growth and a large foreign influx have necessitated heavy outlays of money and a burdensome tax rate. Personal indifference and unsanitary habits are common to foreign persons who settle in a community for the sole object of making money rapidly, and these people usually imagine that liberty extends to the field of personal conduct, regardless of neighborhood rights.

Adequate financial support is indispensable, of course, and funds must be found, but there are many activities which require less money than courage. No higher type of courage

is to be found in modern life than that shown by health officials who calmly withstand influences, social, political and even religious, which would interfere with their strict and impartial application of the health laws and who do it purely from the sense of a citizen's obligation. Such men and women deserve your gratitude and full support.

Generally speaking Pennsylvania's third-class cities can deal with every evil which besets them under existent State and municipal laws. New laws are the least of our needs. Even the control of venereal diseases, including regulation and quarantine, falls within the broad powers given you by law and by ordinance and by local enforcement you may meet nearly every evil situation, provided you have the necessary courage and disposition to do so. A borough may throw the responsibility on the State by refusing to administer its own health matters, although it cannot escape financial responsibility. Not so in the city, however. The city must accept its obligation, administer itself and accept the approval or reproach which by action or inaction it earns and deserves. So let me hastily run over the rights, powers and duties which by law pertain to third-class cities.

Every city of the third-class in its corporate capacity is authorized and empowered to enact ordinances for the following purposes:

To construct and reconstruct sewers and to extend the same beyond the city limits and for the purpose of such construction or extension to take and occupy private lands and property.

To regulate or prohibit the running at large of cattle, hogs, horses, dogs and other animals and fowls.

To make regulations for the enforcement of laws of the Commonwealth relating to the control of communicable contagious diseases, and for the enforcement of the regulations and orders of the State Department of Health; to make regulations to secure the general health of the inhabitants, and to remove, prevent and abate nuisances. To appropriate funds and contract for the collection of ashes, garbage, waste and refuse.

To make all necessary orders and regulations to prevent the introduction of contagious or pestilential diseases in the city; to make quarantine laws for that purpose and to enforce the same. To erect hospitals for communicable diseases.



To provide a system for the inspection of buildings to insure their structural or sanitary safety.

The council of any city of the third-class of the State of Pennsylvania may by ordinance create a board of health.

In all cities of the third-class where the council of said city shall not elect to create by ordinance a board of health, the said council shall exercise all the rights, duties and obligations imposed upon boards of health in cities of the third-class.

Boards of health or councils and commissioners acting as such local health officers with the powers and authorities of policemen. The board of health or the council and commissioner make and publish rules and regulations which when approved by the mayor have the effect of ordinances. Violation penalties and expenses incurred in carrying out regulations are recoverable for the use of the city.

Policemen everywhere, in cities and boroughs should be required to know and enforce sanitary regulations and to warn or arrest those who violate them. When this practice happily prevails everywhere, public health responsibility will be properly distributed and the majesty of the law will cover sanitary ordinances as well as the civil and criminal codes.

Third-class cities and in fact all communities may and should provide and enforce community ordinances securing safe and clean supplies of pasteurized milk at fair prices for their citizens, infant and adult, and they should exclude all other fresh milk supplies as dangerous to health and life.

Everyone must accept a share of responsibility and assume a part in the corrective effort to remove certain present day conditions which are striking at the very life of the people through decreased infection resistance, which results from deprivation of life-sustaining food in sufficient amount.

The recent startling disclosures of nutritional conditions in New York City, as shown by New York Health Department surveys, prove that such absolutely necessary foods as meat, eggs and milk are disappearing from the dietary of thousands of families and, worst of all, from the dietary of thousands of children. Infant mortality, the nation's greatest danger, is enormously increased by this situation.

We are facing a menace, grave, immediate and national which calls for definite governmental action, regardless of the fortunes of any and every profiteer, be he farmer, producer,

distributor, wholesaler, commission merchant, cold storage middle man or retailer.

The impending conflict is really a battle between Individual Greed and the Infant's Right to Live.

No one fears the ultimate outcome or really doubts that right must eventually prevail. But let us who guard the public health not be too prone to invoke the slow processes of that American panacea "education" in the present crisis, but rather let us insist on the application of laws already in existence, depending for justification upon the quickening of the public conscience, without which conscience our nation cannot long endure.

Let me close as I began by bespeaking for the State Department of Health the loyal support of this society and the individual assistance of its members. By this assistance I do not mean such direct and immediate service as the prompt reporting of every case of communicable disease. Such reporting is not a service to the department but to the State, and the violation of this mandate is punishable. Report your cases of contagious disease, of course, as good citizens obedient to the law, but give to the department in a larger way your sympathy, your counsel and your aid.

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### ACUTE INFECTIOUS ENDOCARDITIS WITH CEREBRAL EMBOLISM.

BY

PHILIPP J. R. SCHMAHL, M.D., NEW YORK.

(Read before the Homœopathic Medical Society of the County of New York, November 13, 1919.)

It is stated by students of the subject of endocardial disease that acute bacterial invasion of the inner heart may best be collectively considered under the heading of acute endocarditis, whether they are or turn out to be the simple or the so-called malignant type; *i. e.*, the type does not so much depend on the species as on the virulence of the offending organism. C. S. Williamson says: "The differences between these are equivalent to the differences which exist between a very mild and a very virulent infection anywhere." This paper is designed to arouse discussion of the severe class of case, usually spoken of as septic endocarditis; the more familiar synonyms are: Infectious, ulcerative, malignant, fungating, mycotic endocarditis or thrombo-endocarditis septica.

Before making the formal report I shall digress merely to outline superficially some of the bibliography on the subject, which has a direct bearing on the case under consideration.

"Septic endocarditis should be regarded as of secondary origin in all cases; the exceptions are so rare as to require no consideration." This statement by H. L. Elsner allows of modification to the extent that it may not always be possible to ascertain the primary focus of infection.

The organisms held responsible for attacking the endocardium are, in their order of frequency: *Streptococcus*, *pneumococcus*, *staphylococcus*, *influenza bacillus*, *gonococcus*; the more chronic forms are most often caused by the *streptococcus viridans* and the *pneumococcus*.

The portals of entrance vary greatly: Tonsils, lungs, genitalia, the puerperal uterus, bone-marrow, skin, infected teeth and pyorrhea. It has been said by L. Heitzman that the offending organism may gain entrance to the bloodstream through the upper respiratory passages without causing any greater local manifestation than the "ordinary cold," provided there is a vulnerable secondary receptacle. Insignificant traumatism has led to infectious endocarditis. In the cases following unnoticed primary infection it is, therefore, reasonable to assume that the endocardium has been previously damaged by one or more chronic infections; an attempt to illustrate this point will be recognized in the pathological and necropsy reports.

All clinicians agree that the prognosis of true malignant type endocarditis is unqualifiedly bad.

We should remember that any acute endocarditis, as well as the chronic infectious form may develop into an overwhelming malignant type, depending upon the virulence of the organism and on the resistance of the heart. Again the prognosis shall be carefully formulated, since apparently benign forms have terminated fatally within a few days, while ostensibly virulent types have lapsed into the chronic infectious variety and are stated to have lived from seven to thirteen months. Elsner makes the statement that cases, which showed post mortem extensive granulations and ulcerations, showed no physical signs until within a few hours of death.

Libman, of New York, who has made an intensive study of the disease, has cited cases of subacute bacterial endocarditis with subsequent spontaneous recovery.



With regard to differential diagnosis, especially when dealing with subacute or so-called chronic forms, it should suffice to mention, malaria and typhoid fever, which in the light of present diagnostic methods should readily be eliminated. Yet we may have to deal with a chronic or latent systemic infection, apart from the recent invasion, which may present phases difficult to eliminate from responsibility for the fatal course of the disease. It will be evident from subsequent reports, that such conditions co-existed in the case under discussion, and that, therefore, in the final analysis a great deal of responsibility rests with the latent process, especially in those instances where only an inadequate or no primary focus at all can be demonstrated. It is almost impossible to recognize during life a syphilitic aortitis, unless there is involvement of the valve or aneurism, hence the influence of a pre-existing luetic infection of the great vessel on prognosis is lost, unless signs of aneurism or aortic valvular disease are obtainable.

Early physical diagnosis meets with great difficulties. The amount of dilatation, the character of the pulse, the tension, the loudness of the murmur and intensity of the thrill, all spoken of as classics, may be wanting and not appear until shortly before death. A few brief quotations may not be amiss at this point, bearing on the physical manifestations of the valvular element concerned in our case-report, namely, mitral obstruction. Cabot, speaking of the inconstancy of the murmur of mitral stenosis, which may be very evident at one visit and inaudible at the next, says: "These characteristics explain to a certain extent the fact that differences of opinion so often arise regarding diagnosis of mitral stenosis, and that out of 130 cases in which this lesion was found at autopsy at the Massachusetts General Hospital only 73 or 56 per cent. were recognized during life."

Broadbent and Cabot classifying the physical findings of stenotic mitral disease into three stages, arrive at the following conclusions: In the first stage the apex is little if any displaced, the size of the organ normal or nearly so. The presystolic thrill and murmur are present, P<sub>2</sub> is often reduplicated, usually accentuated. Second stage: Apex is displaced to left, enlargement is obvious; murmur and thrill are longer, P<sub>2</sub> loud and usually double. Third stage: Right ventricular enlargement, presystolic mitral murmur usually becomes inaudible.

a tricuspid systolic making its appearance. The first sound at the mitral area assumes a peculiar snapping quality, which during this stage is the only audible evidence of mitral disease at the apex. The rhythm becomes irregular.

It should be remembered that stenosis of this valve in the majority of cases is associated with and often overshadowed by the systolic sign of regurgitation. These observations have a direct bearing on the early diagnosis of the acute form of endocarditis.

Thus in a given case our evidence may not be found in the physical signs of the heart itself, but derived from the presence of bacteremia, the increased rate of pulse, and the far-reaching general disturbances caused by embolism and infarction of the various organs, notably the kidneys, spleen, lungs and brain. Petechiae are often abundant, especially in puerperal infections. When present, they are of prime diagnostic value. The constitutional symptoms are those of severe bacteremia. Leukocytosis may only be moderately high and present a differential picture, which, under other conditions, may stand for a more favorable prognosis. The appearance of petechiae will signify an impending spread and is rapidly followed by embolism to other organs.

Little can be said about the treatment of these cases. It is my opinion that this sad state of affairs is in direct proportion to the difficulty of distinguishing the early malignant case from the simple type. Were it not so, there might be, at least in the more subacute case, available time for preparing a suitable weapon to combat the hematogenous infection. To the skeptic I would say that this view is backed not only by the many authentic recoveries from puerperal septicemia, but likewise by the personal observation of an extremely severe case of pyemia followed by complete recovery.

The first and foremost injunction is rest to the exclusion of all unnecessary motion in order to lessen the extension of inflammation in the heart and the likelihood of embolism. Elimination must be maintained. The primary focus requires attention. Vaccine and serum therapy, *e. g.*, antistreptococcus serum, have been used. Any underlying condition, which may have rendered the endocardium more susceptible, should be actively treated, if time has not already rendered the case hopeless. Stimulation may be delayed, but digitalis will give the embarrassed heart comfortable support. The remedy selected

in our case was baptisia. The exhibition of this drug did not ostensibly modify the course toward fatal termination. When paralysis ensues, suitable care to meet this situation must be instituted.

The history of our case is inadequate, due not to any lack of effort, but merely to circumstances.

M. J., a colored woman, 26 years of age, unmarried, a nursemaid, was found at Grand Central Station on the evening of October 31, 1919, in response to an ambulance call. Her condition was described as semi-conscious. Patient was admitted to Flower Hospital at 6.20 P. M. Respiration 48, pulse 132, temperature 104 degrees. She was put on infectious precautions. The history obtainable was: Cardiac disease, starting about 14 years ago. Polyarthritis 6 years ago. Baptisia in the diluted tincture was given, also digitalis for cardiac support. She was seen by the writer the following morning and presented the following findings: Lungs, negative; heart, apex palpable in 4th interspace within nipple-line; no enlargement of the organ; a mitral presystolic murmur, slight and not transmitted was heard. No thrill. Slight systolic pulmonic murmur without transmission. No accentuation or reduplication at base. Liver not enlarged. Spleen not palpable. Kidneys not palpable. Skin, mucous membranes and teeth negative, except evidence of moderate pyorrhea. Ears and throat negative. Nose not deeply examined. Pupils are equal and react well to light. No facial paralysis. Slight spasticity of neck and back. Abdominal reflexes not elicited on either side. Right Kernig. No clonus. No Babinsky. Left plantar exaggerated, right decreased. Pain perception equally preserved. There is incontinence of bladder. Pelvic tenderness, but no rigidity. The mental state is dull, irresponsive, at times wandering. Doctor Safford reports a negative pelvic examination, except retroversion. The following night report, November 2-3, notes the appearance of left hemiplegia. Lumbar puncture is performed by Dr. Jost of the interne staff. No increase in pressure, 60 drops per min. 15 cc. of clear fluid obtained. Examination shows a flaccid left hemiplegia with partial anaesthesia in left lower and complete in left upper extremity. My colleague, Dr. H. L. Weil, at this time found as follows: Deviation of eyes and head to right. Palsy left external rectus. Upper neuron type or left facial palsy. Palsy left upper and lower extremities. Rigidity of neck. Babinsky



positive. Petechiae left palpebral conjunctiva. Mitral stenosis.

Drs. Simonson, Hart, and Weil saw the case with the writer on that day, the diagnosis of septic endocarditis with cerebral embolism was patent. The patient now presented a very slight enlargement of the heart, a marked thrill, a rough murmur replacing the second sound at the apex. No sign of pulmonary engorgement. In view of the pathological findings 1 cc. combined pneumo-streptococcus vaccine was given. Urotropin was also added to the medication. The patient's condition became rapidly worse. \*

Fifth day. Swallowing has become difficult, patient can barely be aroused. Respiration 60, pulse 140, temperature 103.8 (rectum).

Sixth day: Four P. M. respiration 64, pulse 140, temperature 106.8 R. Seven P. M. respiration 60, pulse cannot be counted, temperature 108.8 (rectum). Patient died at 7.30 P. M.

LABORATORY REPORT OF DR. LEO. M. POWELL.—Urine: Single specimen, cloudy; acid reaction; gravity, 1021; urea, 2.8; acetone and diacetic acid, absent; urates, numerous; red blood corpuscles, none; pus cells, none; few vaginal epithelia; bacteria, numerous. Blood: White count, 15,200; neutrophils, 89 per cent.; small lymphocytes, 9 per cent.; transitional, 2 per cent.; culture streptococcus hemolyticus, colonies too numerous to be counted; spinal Wassermann, 4 plus positive. Examination of smear from valves at necropsy revealed the presence of short chain streptococci.

AUTOPSY BY DR. J. GOTTERSMAN, NOVEMBER 7, 1919.

GENERAL—Body is that of a young colored woman, with slight amount of rigor mortis. No post-mortem discoloration.

CHEST—No pleural adhesions. No fluid in pleural cavities.

LUNGS—Slight anthracotic pigmentation. *Right*—Crepitation felt throughout. On section upper and lower lobes show numerous areas of consolidation, those in upper lobe being in stage of gray hepatization, while those in lower in red hepatization. Middle lobe normal. *Left*—Also shows numerous areas of red hepatization which are friable to pressure and

on scraping have dry granular reddish appearance. Consolidation more marked in lower lobe.

**PERICARDIUM**—Contains about 60 cc. of thin serous fluid. One small petechial hemorrhage on right wall of pericardium.

**HEART**—Numerous scattered hemorrhages in epicardium. Both right auricle and ventricle are markedly dilated, right myocardial wall being even about 3 mms. in thickness. Tricuspid and aortic valves narrowed. Small area of endocardium beneath right tricuspid valve thickened.

Left auricle dilated. Left ventricle normal in size; wall not hypertrophied. Edges of mitral valve very much thickened and sclerosed and adherent to both auricular and ventricular surfaces are large thrombotic vegetations, grayish red in appearance, soft and friable, removed from their attachments with difficulty and showing underneath an ulcerated endocardial surface. Some of the masses are pedunculated and project into the ventricular cavity.

Aortic cusps thickened and sclerosed. Beginning at the cusps and extending upward along the first and second portions of the aorta are numerous yellowish sclerotic patches varying in size from pin head to half a cm. in diameter extending down to the media. No diminution in aortic elasticity.

**LIVER**—Not enlarged. Slight parenchymatous degeneration.

**SPLEEN**—Not enlarged, on section marked congestion.

**KIDNEYS**—Normal in size, capsules strip easily; underlying tissue showing scattered pale white anaemic infarcts varying in size from 1 cm. to 3 cm., which, on section are found to be confined chiefly to the cortex. Kidney parenchyma shows marked cloudy swelling with scattered millet sized areas of sclerosis.

**INTESTINES**—Negative.

**UTERUS**—Irregularly enlarged by one subserous fibroid located in anterior wall of body and three small pedunculated fibroids.

**ADNEXAE**—Negative.

**DIAGNOSIS**—Broncho pneumonia; chronic valvular disease; syphilitic aortitis; malignant endocarditis; infarcts in kidneys; fibroids.

In view of the fact that we were not permitted to investigate the brain post mortem a point of uncertainty, though not

of probability, arises. The spinal Wassermann being positive and decided evidence of syphilitic aortitis presenting at autopsy we must recall the course of syphilitic endarteritis, in which hemiplegia may come on fairly rapidly. Another interesting sidelight bearing on this case attaches to Cabot's discussion of the Austin Flint murmur. To quote from his chapter on mitral disease: "If there is no dilatation of the mitral orifice, and no regurgitation, any evidence of engorgement of the pulmonary circuit (accentuation of P 2, oedema of lungs), hemoptysis and cough, speaks in favor of an actual narrowing of the mitral valve, while the absence of such signs and the presence of a Corrigan pulse with a predominating hypertrophy of the left ventricle tend to convince us that the murmur is of the type described by Austin Flint, *i. e.*, that it does not point to any stenosis of the mitral valve." And further on: "A positive Wassermann reaction with aortic regurgitation usually means syphilitic aortitis and no mitral stenosis—since the latter is a rheumatic not a syphilitic lesion. Hence a presystolic murmur heard in a case showing good evidence of syphilis and of aortic regurgitation is probably of the Flint type."

It has been shown in this paper that accidents do happen and that, therefore, not necessarily does syphilitic aortitis with a presystolic mitral murmur rule out truly organic mitral narrowing. Had this mitral murmur been attributed to the Flint phenomenon, we would have had a very disheartening surprise at autopsy.

There is no claim in this paper for any original thought. If any step toward progress has been made, it is found merely in our attempt to study our hospital cases as they should be studied. This has at times been impossible for good reasons, but I am glad to state that we are rapidly approaching the time, where the proper co-operation, the necessary interlocking of the departments of clinical pathology and clinical medicine is to be perfected. In this connection I wish to present my appreciation to those who by their co-operation have made it possible for me to work out the case.

904 Bronx Park, South.



## THE INTELLIGENT USE OF DAKIN SOLUTION BY THE CARREL METHOD.

BY

JAMES G. SPACKMAN, M.D., WILMINGTON, DEL.

(Read before the Pennsylvania State Homœopathic Medical Society, Sept. 18, 1919.)

AN effort to discover an antiseptic and germicide capable of aborting and controlling the extremely rapid and virulent infections prevalent in the recent war by the French surgeon Carrel, working in conjunction with the English chemist Dakin; led to the perfection of the solution of sodium hypochlorite, called Dakin's solution, which was used by Carrel's method of instillation through tubes. This treatment is commonly known as the Carrel-Dakin method of chemical sterilization of infected wounds.

The original research work was begun by Carrel and Dakin at the Beaujon Hospital in Paris in December, 1914.<sup>1</sup> It was completed in the research laboratory in Compiègne in June, 1915. More than 200 antiseptics were used before the sodium hypochlorite was selected, because of its marked germicidal properties without cell destruction.

The solution in use at the present time is a solution of sodium hypochlorite which contains not less than .4 per cent. nor more than .5 per cent. sodium hypochlorite; and which is not alkaline to powdered phenolphthalein but is alkaline to an alcoholic solution of phenolphthalein. If the percentage of sodium hypochlorite is less than .4 per cent. the solution has little antiseptic power; if greater than .5 per cent. the solution is irritating. If the solution is alkaline to powdered phenolphthalein, it is irritating. If the solution is acid to the alcoholic solution of phenolphthalein it is unstable.<sup>2</sup>

It is not within the scope of this paper to discuss the entire chemistry of Dakin's solution, but to mention briefly three chemical tests which are of practical importance in the determination of the hypochlorite content and the alkalinity, which are entirely independent, but equally important.

The percentage of sodium hypochlorite is determined by titrating with tenth normal sodium thiosulphate the amount of iodine liberated by a measured amount of Dakin's. Ten cc. of Dakin's solution are put into a beaker containing 50 cc.

of tap water. Add 5 cc. of a 10 per cent. sodium or potassium iodide solution and 3 cc. of glacial acetic acid. Decinormal thiosulphate is then run into the beaker from a burette until the decolorization of the solution is complete. It is often convenient to use a starch solution, prepared by boiling .5 grams of starch with 100 cc. of water and filtering; to make the reaction more pronounced. The number of centimeters required for the complete decolorization multiplied by the factor .0372 gives the percentage of sodium hypochlorite. As example  $13.4 \text{ cc.} \times .0372 = .5 \text{ per cent.}$ , the maximum hypochlorite concentration.

TESTS FOR ALKALINITY.—1. Drop a few crystals of powdered phenolphthalein on 5 cc. of the solution to be tested. Dakin's solution should remain entirely colorless. If any red shows it is too alkaline.

2. One-half cc. of an alcoholic solution of phenolphthalein is squirted from a dropper into 5 cc. of the solution to be tested, which should show a momentary flash of red color. If there is no reaction the solution has so low an alkalinity that the hypochlorite content will diminish very rapidly.

METHODS OF PREPARATION.—Dakin's solution may be prepared by the electrolysis of sodium chloride; by the double decomposition of calcium hypochlorite and sodium carbonate and most easily and satisfactorily by the action of chlorine gas on a solution of sodium carbonate. This latter method has only recently been available because of the difficulty of measuring liquid chlorine. Plate No. 1 shows a diagram of an approved apparatus.

#### TYPE OF CHLORIDE METER.

The method by this apparatus (Fig. 1) is as follows: A solution containing 18 grams of dry sodium carbonate per liter or 21 grams of the monohydrate is prepared. The diffusor of the apparatus is then placed in this solution. The cap is removed from the U tube and water is added until the meniscus in the tube rises to the point zero. Replace the cap and turn on the gas at tank valve. This forces the column of water in the left hand tube down and up in the right hand tube. When the top of the column of water in the right hand tube reaches the 500 point on the scale, enough chlorine is being delivered

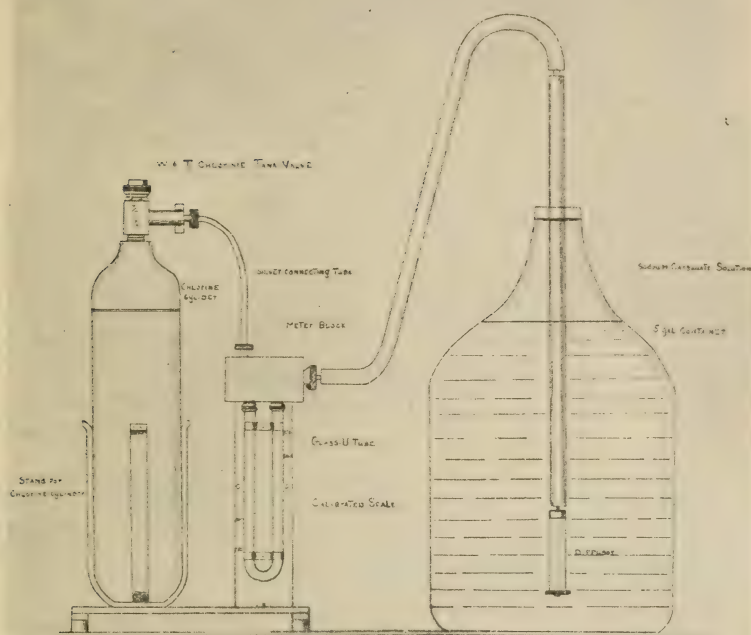
Manufacture from liquid chlorine

PLATE NO. I.

into the sodium carbonate solution to make 500 cc. of a .5 per cent. Dakin's per minute.

The chlorine is turned on for as many minutes as there are half liters of the solution. As example 3 liters of the sodium carbonate solution would require the chlorine turned on for 6 minutes when the scale reads at the point 500.

The solution should then be titrated with the deci-normal sodium thiosulphate solution to prove the required hypochlorite concentration.

**ACTION OF DAKIN'S SOLUTION.**—Dakin's solution is a germicide, antiseptic and deodorant, also possessing the property of being a marvel solvent of necrotic tissue. It is diffi-



cult to give figures of the germicidal effects upon the different pyogenic organisms because of the varied rapidity with which the different media decompose the solution. Most pyogenic organisms in water are killed in less than 5 minutes by a concentration of 1:100,000, while in serum 1:1500 is necessary. When blood is present about 1:300.<sup>3</sup>

The solution is actively hemolytic and is rapidly decomposed after contact with organic matter as are the other members of the chlorine group, hence the necessity of frequent renewal.

DECOMPOSITION OF DAKIN'S AFTER CONTACT WITH MUSCLE AND PLASMA.—The hypochlorite content upon which the solution depends for its germicidal action disappears within 3 to 5 minutes after coming in contact with wound secretions. This is accelerated by the presence of blood. Chloramine compounds remain in wound for 3 to 6 hours and exert an inhibitory action upon the micro-organisms.

Plate No. 2 represents, by means of a plotted curve, the

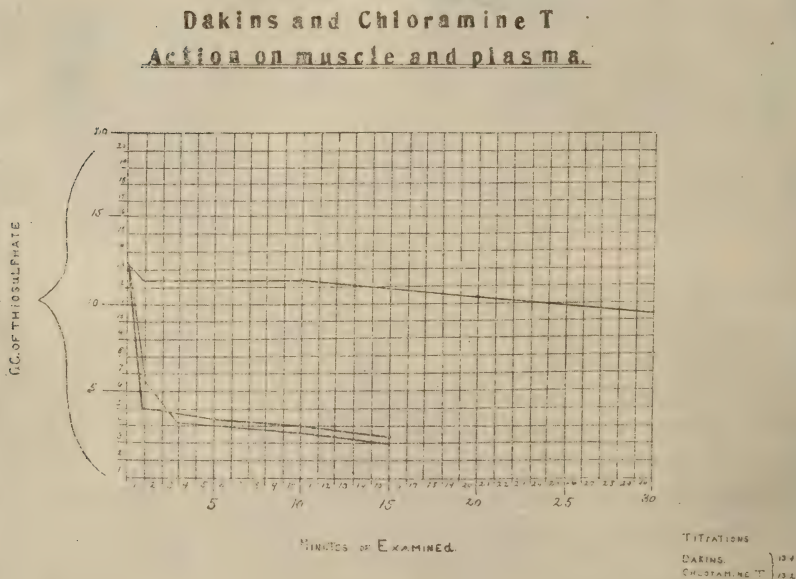


PLATE NO. 2.

drop in the chlorine content following the contact of the solution with muscle and plasma. The figures at the left hand side representing the number of cc. of sodium thiosulphate required to completely decolorize the solution. The figures at the bottom denote the number of minutes of exposure at which time the solution was titrated. Topmost tracing representing a solution of chloramine T. Second and third lines solutions of Dakin's upon muscle and plasma respectively.

The Chloramine T shows a relatively small drop of 3.2 cc. in 30 minutes. The Dakin's solution within 5 minutes dropping to 4, a decrease of 9.4 cc., or a hypochlorite content of less than .1 per cent. which is below the point of concentration necessary for any germicidal action. The decrease after 5 minutes is more gradual.

The foregoing chart shows the necessity of adherence to one of the fundamental principles, viz., that the solution must reach *all* parts of the wound at the *same time*. This being accomplished by the proper distribution of the tubes.

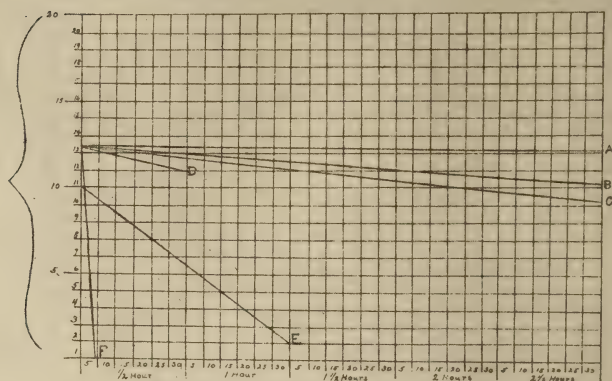
DECOMPOSITION CAUSED BY EXPOSURE TO SUNLIGHT AND CHEMICALS.—The solution is decomposed by exposure to sunlight, hence should be kept in amber bottles or bottles protected by paper. Alcohol or hydrogen peroxide should never come in contact with the solution because of the immediate decomposition.

Chart No. 3 shows, by means of the same diagrammatic tracing as Chart No. 2, the effect of these exposures. The solution in all cases being a .5 per cent. and titrating 13.4 cc. before exposure.

The line A exposure to sunlight in an amber bottle for 3 days. Deterioration of only .4 cc. of no practical importance. Line B exposure for 2½ hours in a colorless bottle. A drop to 11 cc. giving a .4 per cent. solution. The lowest possible concentration. Line C shows this action accelerated in the same length of time by the addition of a few crystals of potassium permanganate. Line D boiling for ½ hour causing a drop of 1.4 cc. or a percentage between minimum and maximum. Line E the addition of 1/5 volume of alcohol causing a drop of 11.4 cc. in one hour, making a worthless solution. Line F the addition of 1/5 volume of hydrogen peroxide causing an immediate drop to zero in 5 minutes.

EFFECT CAUSED BY INJECTION INTO PERITONEAL CAV-

### Effect of exposure and addition of chemicals on Dakins solution



MINUTES OF EXPOSURE.

DAKINS TITRATION, 13.4

A: EXPOSED TO LIGHT IN AMBER BOTTLE 3 days.

B: EXPOSED 2 1/2 hours IN COLORLESS BOTTLE.

C: EXPOSED 2 1/2 hours IN COLORLESS BOTTLE WITH KMnO<sub>4</sub> ADDED.

D: BOILED FOR 30 MINUTES.

E: ALCOHOL ADDED 1/2 VOLUME.

F: HYDROGEN PEROXIDE ADDED 1/2 VOLUME.

CHART No. 3.

ITY.—As the solution is actively hemolytic it should never be injected into the peritoneal cavity unless the same is walled off from the free cavity by dense adhesions as in old abscesses.

Plate No. 4 shows the usual immediate drop of the hypochlorite concentration of 11.2 cc. within 5 minutes of injection, a zero point being nearly reached in 10 minutes. In this experiment 300 cc. were injected into the free peritoneal cavity of a dog. The solution was removed with a pipette and titrated at 5 and 10 minute intervals. Death was caused within 45 minutes by a profuse hemorrhage of the small intestine at its mesenteric border. The great omentum was entirely dissolved of its fat, the connective tissue only remaining.

PREPARATION OF RUBBER INSTILLATION TUBES.—The instillation tubes are made from 99 per cent. pure rubber with no free sulphur, lead or antimony. The inner diameter is 4 mm. Tubes are three kinds: Plain, covered and special, and are numbered according to the number of centimeters for



## Dakins solution after injection into the peritoneal cavity.

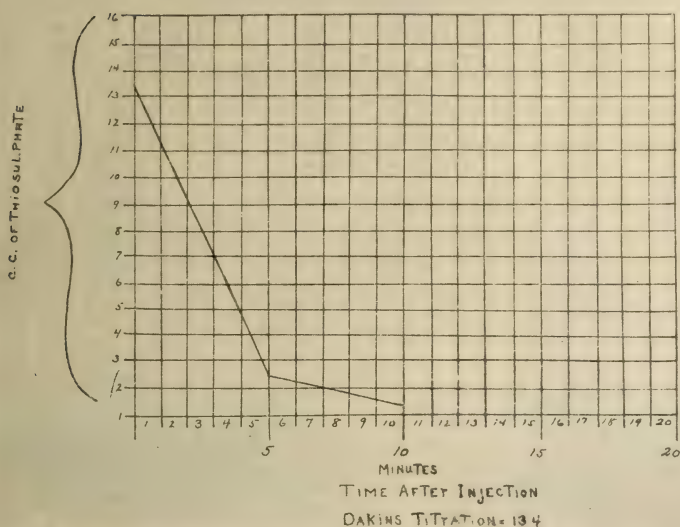


PLATE NO. 4.

which they are perforated, by means of a special punch of  $\frac{1}{2}$  and 1 mm. diameter.

Plain tubes are made in numbers 1, 5 and 10. Each is 30 cm. in length. The number 1 tube is the only tube that is not ligated at the end. This tube has an opening 2x4 mm. 1 cm. from the end. Number 5 and 10 tubes are made by measuring off 30 cm. of tubing. The end is ligated with a hitch knot and a distance of 5 or 10 cm. is then marked off. A zero perforation is made as close to the ligature as possible. The odd numbers are then marked off with a centimeter rule as in a number 5 tube, the perforations are made with a punch opposite the centimeters 1, 3 and 5. The punch used perforates both sides at once. The tube is then rotated through an axis of 90 degrees, and the even centimeters 2 and 4 perforated. This gives an equal distribution of fluid from the tube in all directions. Tubes numbers 15 and 20 are made in the same manner except that they are 40 cm. in length.

Tubes covered with Turkish toweling are made in numbers 5, 10, 15 and 20. The toweling should always be cut 5 cm. longer than the length of the tubing and 5 cm. in width. All cut edges are turned in when the toweling is sewed.

Empyema tubes are 50 cm. in length and are perforated for 10 cm. These may be stiffened with No. 22 gauge silver wire for a distance of 30 cm. through the center of the tube. This assists in maintaining the tube in a given fixed position, which is otherwise impossible in the unstiffened tubes when placed in a large empyema cavity.

Loop tubes 70 cm. in length and perforated for 10 cm. on either side of the mid point are of use in a wound of the extremities having a continuous superior and inferior surface.

The glass distributors are made with 1, 2, 3, 4, 5 and 6 divisions. Containers are of amber colored glass and should hold 1000 cc. Plate No. 5 shows the different types of Carrel tubes and glass distributors for same.

Types of Carrel tubes and glass distributors.

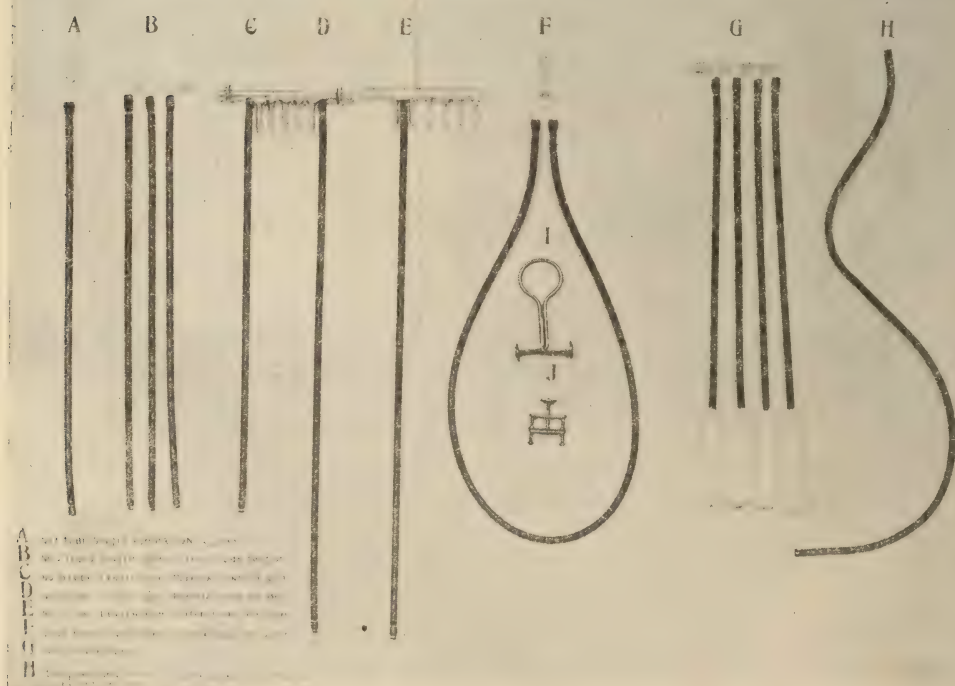


PLATE No. 5.

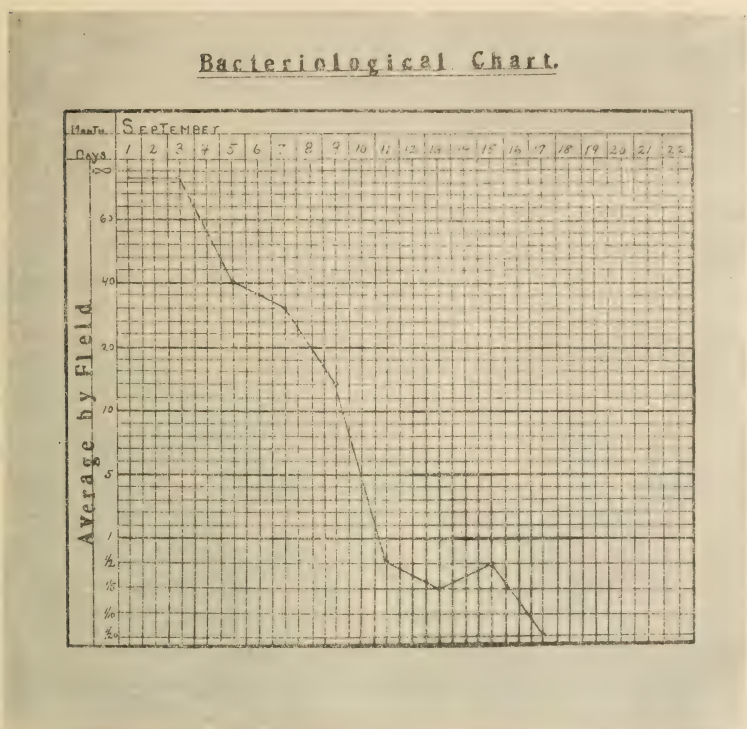


PLATE No. 6.

**BACTERIOLOGICAL CONTROL OF WOUNDS.**—This is an essential part of the method of treatment. Plate No. 6 shows the standard form of chart. The bacteria above 60 per microscopic field being designated as infinity. Graduations range from infinity to 1 to 20, *i. e.*, one bacteria to 20 microscopic fields.

The smears are taken every other day with a platinum loop upon a glass slide. Precautions to be observed are: (1) That the smears be taken from the worst part of the wound; (2) That the wound shall not have been flushed for two hours previous to the time of making the smear. Stain with methylene blue or carbolfuchsin. Three to five fields are counted if there are more than 40 bacteria per field when averaged. Below 40, count 10 to 20 fields and take the average.

Precautions to be observed in counting are: (1) Select fields thick with polynuclears; (2) count enough fields; (3)



represent the whole slide; (4) count the bacteria within the leukocytes.

A bacterial count averaging one bacterium for five fields for two successive counts taken on alternate days, constitutes the time for closure in simple wounds. This can usually be secured in from two to five days. Complicated wounds should have six to seven successive counts of one bacteria to five fields before closure. This may require six to fourteen days.

Plate No. 6 shows the bacteriological chart of a large shrapnel wound of the thigh. Sterilization and closure in seventeen days.

TECHNIQUE OF APPLICATION OF TUBES.—The treatment as a whole consists of three essential parts:

(1) Mechanical cleansing, *i. e.*, removal of all dead and severely injured tissue and foreign debris.

(2) Chemical sterilization.

(3) Closure of the wound, which may be accomplished by suture, strapping with adhesive; or lacing the wound by means of a suture laced from side to side of the wound on hooks which are fastened on lateral strips of adhesive placed on either side and at some distance from the wound edge. Excessive tension should always be avoided, by undercutting or lateral incisions.

Chemical sterilization is accomplished by means of continuous irrigation or intermittent instillation, at two hour intervals, of all parts of the wound with Dakin's solution. The size and number of the tubes used are entirely dependent upon the size and extent of the wound and no definite rules can be laid down. The objective being that the tubes shall be so placed that the solution will reach *all parts of the wound at the same time.*

Number one tubes are the only ones that should be used with a drop counter in continuous irrigation. These are of value in cup shaped wounds that have a definite cavity capable of holding an appreciable amount of the solution. If it is desired to use more than one number one tube a second container should be arranged.

Important points in the use of the other tubes are:

(1) Use tubes only of the same number from the same glass distributor, as the amount of fluid delivered from each tube is entirely dependent upon the resistance offered. As for example two No. 5 tubes and two No. 10 being used on the

same four-way distributor, the two No. 10 offering only one-half the resistance of the No. 5 tubes, because of double the number of perforations, deliver twice the amount of fluid to their area of distribution.

(2) Turkish toweling tubes can be used to advantage on wounds upon whose surface it is impossible to keep any appreciable amount of the solution in contact by use of the plain tubes. Large granulating areas are an example, used when it is desirable to secure an aseptic surface preparatory to skin grafting.

(3) No gauze should be placed between the tubes and the wound surface.

(4) After fixing the tubes in the desired position by means of adhesive on the skin at some distance from the wound surface, the extreme ends of the tubes connected to the glass distributor should always be fixed in a superior position so that they will not act as drains for the fluid when instilled.

(5) In the introduction of the stiffened empyema tubes an effort should be made to come in contact with the superior, inferior and both lateral surfaces of the wound by the use of four tubes properly curved.

(6) In seton wound possessing a superior and inferior opening, the tubes should be placed in the superior one, and the inferior opening plugged with gauze, so as to prevent immediate drainage of the fluid.

(7) No pain should be caused by the pressure of the solution. The bottle should be placed two feet above the wound surface when two tubes are used. When more than two, place container at three feet.

(8) Each tube should receive 10 to 20 cc. at two hourly intervals. This may either be given by releasing the pinch cock on the rubber connecting tube which connects the container bottle with the glass distributor or in ambulatory cases by means of a glass syringe.

PROTECTION OF SKIN SURFACES.—The skin surfaces surrounding the wound should be protected by vaseline gauze which is easily made from bandage gauze cut in convenient sizes as 3 cm. X 7 cm. These are put in a tin biscuit box and the box filled with melted vaseline. The excess is poured off after thorough saturation, and the lid is fastened on with

adhesive and the same placed in the autoclave for sterilization.

Gauze pads made of one layer of absorbent cotton and one layer of non-absorbent, both being covered with gauze are placed over the lighter gauze of the wound, with the non-absorbent side out.

The wounds should be redressed daily at which time the wound surface should be cleansed with a sterile solution of neutral soap followed by a light sponging with compresses saturated in Dakin's solution. This removes the chlorinated wound secretions which are mucoid and tenacious in character. The tubes can then be tested with a syringe, making sure that all perforations are patent. New tubes are put in place when they become clogged or foul.

Wounds having a free purulent secretion should become free of the same within 48 hours after the use of the solution. The secretions becoming light mucoid in character.

CONCLUSIONS.—(1) The method is not a substitute for recognized surgical procedures but is to be used in conjunction with them. Complete debridement, opening up of every part of the wound, is the primary requisite necessary for the proper use of the instillation tubes.

(2) It is possible to abort infections when received in the first 24 hours and to control the same and produce a wound sufficiently free from bacteria within 2 to 16 days, when the focus of infection is reached, to close the same in over 90 per cent. of cases with primary union.

(3) The number of days spent in hospital by cases with infected wounds is greatly reduced.

(4) The procedure offers a scientific method of constantly bathing the surfaces of wound with an antiseptic without changing the dressings more than once in 24 hours, and without pain to the patient.

(5) The method is most applicable in a well organized surgical service in which the internes and nurses have received a practical course of instruction in the salient features of the method.

(6) The writer knows of no short cuts, or modifications. Strict adherence to the correct technique as laid down by Carrel is essential to obtain the best results. The importance of *time, concentration and contact*, *i. e.*, sufficient concentration to obtain the maximum germicidal action with-



out irritation, and contact with all parts of the wound at the same time, are the key notes of success.

#### BIBLIOGRAPHY.

1. Sherman, W. O., Surg., Gynec. & Obst. 1917, XXIV, 255.
2. Dakin, H. D., British Med. Jour., Aug. 28, P. 318, 1915.
3. Dakin & Dunham, Handbook of Antiseptics, P. 27.
4. Experiments performed while attending a course of instruction given at The Rockefeller Institute, N. Y.

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### A PROVING OF MENTHOL.

BY

WILLIAM B. GRIGGS, M.D., PHILADELPHIA.

Director of the Hering Laboratory, Hahnemann Medical College of Philadelphia.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

MENTHOL is the stearopten from the essential oil of mentha perita. It occurs in colorless crystals having a strong peppermint odor. It is soluble in alcohol, ether, bisulphide of carbon, oils and acetic acid; and is very slightly soluble in water. It melts at 110 degrees F. It may be fused or compressed into cones or pencils. Chinese and Japanese oils of peppermint are richer in menthol than the official oil.

PHYSIOLOGICAL ACTION DEDUCED FROM THE PHARMACOLOGICAL STANDPOINT—Menthol in the frog paralyzes the spinal centers; then the nerve trunks. Small doses excite, while large doses paralyze the heart and cause the respiration to become shallow and slow. There is irregular reduction of blood pressure and loss of sensibility, the animal growing quite cold. Binet recently showed that menthol was not eliminated by the lungs, as at one time believed to be the case. The sensation of cold produced by menthol when applied locally was shown by Goldschneider not to be due to actual lowering of the temperature of the surface. In fact, the application of a solution of menthol, he found to be followed by a rise of two degrees C. He, therefore, attributed the sensation to the influence of the drug upon the peripheral nerves of sensation; an action quite independent, also, of evaporation. This can be corroborated by anyone exercising a little careful technique. It will be seen later on that the pharmacological investigations on the lower

animals do not correspond very closely with the pure dynamic defects upon man.

The following proving was conducted by myself in the Hering laboratory, assisted by twelve male provers and two female. The actual time of the proving was fifty-two days, when the symptoms produced greatly interfered with the students' work, and had to be discontinued. Some of the provers suffered persistent catarrhal and neuritic symptoms for four weeks before giving up, which will prove the genuineness of the symptoms. The proving was conducted along modern scientific lines; the students on the proving squad had beside the thorough examination, as devised by the Hering laboratory, also their army examinations. Their day-books were carefully examined, as well as the provers themselves. Symptoms began from two to four days after beginning the drug. The dosage was from an empirical tincture made by dissolving two drams of menthol crystals in two drams of 95 per cent. alcohol. Dilutions were made from this tincture, using the 2x and 6th centesimal potency. Symptoms of various types and degrees, with various modalities, were brought out by each preparation. The symptoms here recorded were pronounced and persistent in all provers who stuck to the end of the proving, and many have been confirmed clinically. We, as homœopaths, know each medicinal substance has an individuality, a unit of sensations and conditions; and by skilful application of this medicinal unit to the individual having a similar unity of symptoms and conditions, the sick are made healthy. Hahnemann says: "We must know the pure effects of medicines upon the healthy human being in order to confirm the 142d paragraph of the *Organon*, namely, 'When a proper application of the homœopathic remedy has been made, the acute disease which is to be cured subsides in a few hours, if recent, and in a few days, if somewhat older.'" So, to accomplish such wonderful results, we must work in our *materia medica*, honestly and consistently.

Menthol does not produce such a vast array of symptoms, but it produces a few well-defined symptoms, with some change in tissue structure.

THE GENERAL PATHOGENIC RANGE OF MENTHOL.—Menthol exerts its greatest action on the mucous membrane of the naso-pharynx, less intense on the gastro-intestinal tract, and quite marked action on the spinal-nerve plexus, producing

various neuralgias, neuritic pains and paresthesias; also irritation of the genito-urinary tract.

THE GENERAL THERAPEUTIC RANGE OF MENTHOL.—Menthol has proved curative in acute nasal catarrh, both anterior and posterior; acute catarrh of the eustachian tubes with otalgia and catarrhal deafness, pharyngitis, laryngitis, orbital and facial neuralgias, intercostal neuralgia, nausea the result of nervousness or emotional excitement, nervous dyspepsia and diarrhea, and buccal exudates.

#### THE PURE PATHOGENIC EFFECTS UPON THE HEALTHY PROVER, MOSTLY IN THE PROVER'S LANGUAGE.

*Mind and Head.*—Menthol produces a dull, sleepy feeling, with a sense of warmth and general oppression; mental confusion; frequent inability to grasp facts as usual; wearied feeling; light headedness; dizziness on bending the head forward; occasional paroxysms of mental irritability; soreness of the scalp; a feeling of fulness, associated with pressure in the frontal region; sore, bruised sensation at exit of the supra-orbital nerve, much worse over the left eye, going over to the right side, and developing almost as severely there. This is accompanied with intense soreness and some swelling, aggravated by pressure. There is also frontal headache, very severe over the frontal sinuses, with much heaviness of the eyeballs. This pain continued steadily in Mr. McLeary for two weeks. Frontal pains seemed to descend into the eyeballs.

A symptom continuing in several provers during most of the proving was as follows: Constantly dull, penetrating frontal and parietal headache, with a sense of fulness in the head, worse from motion or bending the head forward, accompanied by sensitiveness of the eyeballs; also twitching pain between the left eye and ear, extending up and down for a couple of inches. A peculiar and valuable symptom was developed on both sides of the face above the zygoma—twitching, at times, with numbness and anesthesia of the same region; very sensitive to touch after sensation became restored. The anesthesia was tested out by the neurologist. The supra-orbital neuralgia over the left eye was the most severe head pain recorded. Dull, steady headache in the pretemporal region. Pain goes in very deep, is particularly worse on the right side, and finally settles in the frontal region and above the ears.



Many frontal sinus pains were recorded. At times, the head feels large. Pains are felt in the vertex, of a throbbing character, worse after supper, and worse on moving.

*The Eyes.*—Dull, aching pain in the eyeballs, coming on at 4 P. M.; pains around the eyeballs, encircling the orbits; heaviness in the eyeballs, accompanying the frontal headache. At times, the eyeballs feel compressed. There is a dull, throbbing pain in the eyes, worse on the left side. This frequently accompanies the frontal headaches. Congestion of the eyes, with a sensation as though they had been exposed to cold air, is also noted.

*The Nose.*—Dull, stuffy feeling in the head and nose; nasal catarrh developed, both anterior and posterior. It began with a white, clear discharge, always worse in the morning. Frequent sneezing occurred; a great deal of postnasal dripping; and, as the proving was pushed, there developed a whitish, viscid postnasal discharge, with bloody streaks; also a thick yellow nasal discharge. This was developed by the 2x. The local examination showed an irritated and inflamed mucous membrane of the whole naso-pharyngeal cavity; a cold, dead sensation in the nose on deep breathing, with some loss of smell.

*The Ears.*—Sharp pain, starting one and one-half inches behind the right ear, extending vertically downward as far as the right scapula; worse from pressure and motion. Dull, grinding pain in right occiput, extending to the mastoid region, which is tender to touch. Painful soreness back of the right ear in the mastoid process, worse from motion or pressure. This continued nine days, and the prover quit. Eustachian tubes feel blocked, with nondescript pain and some deafness. This has been verified.

*The Face and Inner Mouth.*—Face pale, with a slightly jaundiced hue; after two weeks, several of the provers began to lose in weight and look badly, felt tired. After a rest of two or three weeks, they began to improve again, coming back wonderfully. They gained weight and lost the catarrhal symptoms. Little white patches and ulcers developed on the inside of the lower lip and buccal cavity, about a quarter of an inch in diameter, very sore to touch. Laboratory examination was not permitted as the provers became impatient and had the spots touched up with tincture of iodine. Some of the patches looked

like a false membrane. Thirst and dry mouth occurred, much water being taken at times.

*The Throat.*—Tickling and irritability in the fauces; a constriction coming daily at 1 P. M.; fauces red and swollen; some cellular infiltration, but no true edema; difficulty in swallowing, but without pain; tickling in the lower posterior part of the throat, very persistent. The left fauces are red and swollen; the inspired air feels cooling. On examining the post-nasal space, it is frequently found covered with various types of mucus.

*The Respiratory Organs.*—Sharp pains in the precordium, continuing for one hour at a time; tearing pains, worse on deep breathing; soreness in the left chest wall, worse on deep breathing; sudden stabbing pains in the region of the heart on deep inspiration; stabbing pains in the precordia, radiating over the entire chest, continuing for three days. Menthol produces a very short, dry, non-productive cough, very incessant at times, and is brought on by the peculiar cool feeling in the larynx or the tickling down in the fauces. Almost every effort to smoke a cigarette immediately excited this cough. A sense of fulness in the chest was present. Both female provers developed an asthmatic type of breathing, with congestion in the head; a violent throbbing, as though the head would burst at the vertex, accompanied with depression and irritability. This was entirely new to the provers.

*The Stomach and Abdomen.*—A feeling of warmth in the pit of the stomach; a heavy feeling with great flatulence, worse when the stomach is empty; a nondescript type of pain, with no physical findings, evidently a gastralgia. Nausea, most pronounced in the female provers, would last for hours, with no relation to eating or foods; accompanied with a fine tremor in the stomach and a sense of warmth or chilliness. If the nausea was very severe, and the chilliness of long duration, diarrhea would follow. Straining at stool occurred; it has produced actual constipation for three days at a time in both sexes. Dull grinding and cutting pains in the right and left inguinal region, worse finally on the right side, and worse at 7.30 P. M. Dull, grinding pain in the right inguinal region, as if something were pulling downward.

*Urinary and Sexual Organs.*—Sharp, burning pains in the meatus during urination, usually beginning at 5 P. M., occurred in most provers forty-six days after the proving was

begun. The urine continued very scanty for days. The urinary findings were increase of urates and an abundant mucous sediment. Neuralgic pains along the right spermatic cord; crawling sensation on the scrotum. In the female, just before the menstrual flow began, there commenced a slight irritation at the vaginal orifice, presenting various types of paresthesia; as a crawling, biting, tickling sensation, intensely aggravated by scratching, and ameliorated by holding hot compresses to the vulva. This never had occurred to the provers before, and lasted for a week after the menstrual flow ceased.

*The Neck, Back and Extremities.*—The muscles of the neck feel stiff. Muscular pains in the right posterior cervical region, made worse by motion of the head; sharp, cutting, tearing pains in the left lumbar region, worse on deep inspiration; marked soreness in the lumbar muscles. Twitching pains in the left elbow, coming on at 6 P. M. daily, leaving the elbow sensitive to touch.

*Sleep and Fever.*—Disturbed sleep, particularly towards morning, evidently the result of the postnasal catarrh dripping down in the pharynx. (I quote prover McLaren). Restless sleep; dull and sleepy when in doors. This occurred in students usually full of "pep." Sleepiness and weary feeling. Difficulty in getting to sleep.

Chill at 7 P. M.; chilly during the night. Chill began the next day in the afternoon, and continued more severe; then was followed by a spell of warmth. The temperature taken during the chilly stage was normal, with an increase of two degrees during the warm stage. After these chilly symptoms, there also developed some vasomotor disturbances of the skin, such as small, pale spots of urticaria.

This drug may be compared with many remedies. After studying the provers and having to antidote symptoms at various times, when the prover rebelled, I would suggest, in the neuralgias and migraine, comparing aconite, kali bichromicum, kalmia, bryonia, capsicum, gelsemium, spigelia and prunus spinosa.

In the nasal catarrhs, compare ammonium carb., corallium rubrum, kali bichromicum, kali mur and the natrum salts.

I wish to express my gratitude to all of the students of the proving so far; especially I wish to publicly thank Messrs. Harold J. McLaren, John C. Wienski, Hosea, Briggs, Johnson, Lynch, Ziegler, Bohn and Bier for continuing more or less to



the end of the proving. Also I wish to express my indebtedness to my clerks, Dr. Leslie K. Fry and Dr. George Goeckler. The profession is asked to put this drug to the clinical test, and thus enrich our homœopathic materia medica by new confirmations.

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## THE DOSE.

BY

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(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

WITH a few preliminary remarks I would dismiss the potency question from consideration in this paper for the dose is not the potency, trituration, or tincture that may be used, but the quantity of these that may be administered to a patient at a time and the frequency of its repetition.

Incidentally, however, I would express my full accord with Jousset in regarding the secondary effect of drugs as contributing a legitimate sphere of homœopathic activity and not as Hahnemann preferred to consider it the simple reaction of nature from the primary effect of the drug.

If a single instance can be found where the drug produces its so-called secondary effect at once without the previous intervention of its primary effect it would be conclusive evidence that the secondary effect is the direct result of drug action. Jousset mentions three such instances—a large dose of digitalis producing asystolia without preceding slowing of the pulse or increase in arterial tension; a large dose of opium at once causing coma without the preceding stage of excitation and the fact that a large dose of strychnia causes in the frog a resolution of the limbs without the preceding tetanic state and what is more remarkable and absolutely conclusive, if the frog is placed in the open air when the elimination of strychnia has proceeded to the proper point the tetanic symptoms appear which constitute the primary action of the drug.

We, therefore, turn to the consideration of our paper with the knowledge that the small dose or the larger dose is a legitimate part of homœopathic prescribing as it is given for the primary or secondary effects of the drug.

Our subject is apparently a matter of little or no interest to homœopathic prescribers. It is the rarest thing imaginable for the report of a case to contain the dosage of the remedy employed. If the potency used is mentioned this is considered to be all-sufficient—no mention is made of the quantity employed or of the frequency of its repetition. In many instances the remedy is named, but the preparation of it that was used is left to the imagination of the reader. Sometimes after an interesting case has been reported in this incomplete manner some one inquires what potency did you use, and on one occasion the answer was, "Damn the potency; give the remedy."

Is it not strange that homœopathic literature up to the present time continues to exhibit this weakness and imperfection? When those not of the homœopathic school use remedies homœopathically, they are careful to prescribe the dosage as we shall show by several examples from eclectic sources.

It may be that because the homœopathic dose is always a safe dose that it is considered unnecessary to mention it. This, however, is a poor reason for if it were only for psychological purposes, these would be forceful reasons for giving the dosage.

Anyone of scientific mind looks for perfection of detail in the report of demonstrations. The mere absence of some detail of technique in the report of a surgical operation is frequently sufficient to weaken the appreciation with which it would otherwise have been received. There is the same reason for perfection of technique in the report of a medical case. Homœopathists should, of course, know the ordinary dosage of remedies because it is from their administration in any quantity less than that which produces their physiological action, that their homœopathic action is derived. The emetic dose of ipecacuanka is from 5 to 20 grains according to age or susceptibility and the homœopathic dose given to control emesis must be less than 5 grains usually, and certainly always less than 20 grains. However, one dose does not always cause emesis and it is frequently repeated at intervals of 15 minutes—neither does one dose administered homœopathically always control emesis so that it is advisable to give directions for its repetition.

Homœopathy claims to be a system of therapeutic exact-

ness but this statement is commonly belied by the slipshod methods used by its followers. One physician adds without measurement a quantity of tincture or dilution to a half-glass of water and without stirring or directing that it be stirred, orders a teaspoonful of the mixture every one, two or three hours as may be required. Another uses about the same quantity of medicine and water but always directs that two teaspoonfuls of the mixture be taken.

Neither of these prescribers has the slightest idea of the quantity of the remedy taken by the patient at the respective intervals. Now, granted that it is not essential that they should know, because the remedy acts without precision in its administration, it still is necessary that they should know, if they claim scientific accuracy in therapeutics and if they would steer clear of a careless, sloppy method in prescribing.

In a very recent reprint by a distinguished physician there occurs this statement: "Those who once stood askance at the idea of even the 6th potency having curative effect are now assured that the dose can not be too small to produce results." Now, what dose does he refer to? The 6th potency is not a dose—it is a preparation, but the quantity of it that is administered at one time is the dose. Whether we prescribe the lowest potency that can be made from the tincture which is the 2x or a high potency such as the 200th or 1000th, we should state how much of these preparations is to be taken at a given time.

Physicians outside the homœopathic school when using its remedies, are as careful to give the dosage as they are when using other drugs. The following extract from a well-known eclectic work is a model for homœopathists to follow: "In tonsilitis, where first one tonsil, then the other is affected, give *lac caninum* 30th decimal dilution. Place 20 drops in half a glass of water and give a tablespoonful every half-hour."

Incidentally it is very interesting to note how very many eclectic remedies are prescribed (wittingly or unwittingly) according to the principle of similars. In one of their handbooks out of fourteen remedies recommended for abdominal pain twelve are given for the same symptoms that we find in our own text-books. It was for this reason among others that the writer in his presidential address to the American Institute



of Homœopathy in 1912 advocated the union of these two schools.

To go back to the eclectic hand-book—take one of these remedies—*chamomilla*. It is given “for flatulent colic, usually with a diarrhoea with green discharges and of foul odor. Patient is irritable and oversensitive—little ones have abdominal pain and want to be carried, head sweats, cheeks alternately red and pale. Dose, add 15 drops (sp. med. cham.) to 1 dram to 4 ozs. water. Mix and give teaspoonful doses every 15 minutes to 1 hour.”

Take an example from another eclectic book: “In paralysis of the left side of the body due to apoplexy, with great weakness, faintness, prostration, both mental and physical, trembling of the tongue, worse in the morning, lachesis should be prescribed. Dose, 10 drops of the 6th decimal dilution in half a glassful of water, teaspoonful once in two hours.” A homœopathist would give the same remedy but the dosage would not be mentioned.

One more illustration from the handbook: *Magnesia phos.* 3x for sharp, quick, spasmodic pains, pains relieved by hot application and by bending double. Dose, two grains in hot water every 20 to 30 minutes.

How much more satisfactory are these examples of definite dosage from eclectic sources—how much better to have the complete medical technique!

Our own neglect of this matter has led us into careless practices. Once in consultation after the remedy had been agreed upon, the writer saw the physician empty a powder in a glassful of water and leave without even directing the nurse to stir until it was dissolved.

It is quite possible that from a psychological standpoint this looseness in homœopathic practice has prevented some careful minds from thoroughly investigating our therapeutic claims. Starting with the intention of examining a system of therapeutics which claimed definiteness and precision from its foundation upon a law of cure, they find no system in the administration of the remedies by which the truth of that law is to be shown and turn from it with distrust.

It is also possible that some of our own physicians have lost their enthusiasm for homœopathy from this same lack of clear cut precision in the reporting of cases, and in the use of remedies.

The writer has seen a physician make up a number of powders of pure milk sugar in bibulous paper and after the powder was finished, let a few drops of the 200th dilution fall on the outside of the powder paper. He has seen another physician take a 4 oz. bottle containing just sufficient medicated globules to cover the bottom, fill the bottle with dry globules and after shaking be satisfied that he had his remedy, but he did not know what he had, nor had he any idea of its dosage.

Our decimal system affording as it does the same unit of strength for both solid and liquid remedies, should be of the greatest advantage in the establishment of a definite dosage.

Our initial liquid preparation the tincture being 10 per cent. drug strength is also properly known as the first decimal dilution of all the soluble material existing in the plants or other substances used in its preparation. It thus corresponds in drug strength with our 1x triturations which represent in each grain one-tenth of a grain of the crude material.

When 10 or 15 drops of the 3x dil. are added to a half-glass of water the patient receives not the 3x but something above the 4x dil. If it is desired that the patient shall take the 3x then two glasses should be used, one of which should contain water which should be measured by the teaspoonful into the other glass. One or more drops of the 3x should then be added for every teaspoonful of water that has been measured. The patient will then receive one or more drops of the 3x in every teaspoonful taken.

If a trituration or tablet of the 3x has been given then it should be stated that the remedy was in the 3x trituration. Dose, one tablet or powder every 1 or 2 or more hours.

The matter of convenience in dispensing liquids by pouring them over globules or disks prevents accurate dosage. We can, however, approximate here by knowing that it takes about 15 drops of a potency to medicate two drachms of number 40 globules, and by mentioning that the dose is 5 globules every 1, 2 or 3 hours as may be required.

Now the writer knows how hard it is to alter the habits of a practitioner especially if it is in a matter that he regards of minor importance, but we should do all that is possible toward perfecting the methods of homœopathy. In the Homœopathic Pharmacopoeia of the United States we have a method for making fresh plant tinctures that in all probability will

remain as one of the finest achievements of pharmaceutical art. Let us insist that our pharmacists make their preparations according to its directions. There should be absolute uniformity in the preparation of our remedies. Then let us always mention the dosage in reporting cases and our literature will have double value.

In a recent paper Dr. C. E. Sawyer, President-Elect of the American Institute of Homœopathy says: "Therefore, I feel safe in saying that from here we are going to a place where the law of similars will be known as the fundamental principle of all medical prescriptions, and those who have jeered will be claiming credit and usefulness for principles which hitherto they failed to recognize and employ."

Meanwhile, let us improve our literature and complete our technique by always including in our reports of cases—the dose.

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## PRESENTING A NEW INSTRUMENT FOR THE APPLICATION OF RADIUM IN THE URINARY BLADDER.

BY

LEON T. ASHCRAFT, M.D., AND F. C. BENSON, JR., M.D., OF  
PHILADELPHIA.

(Read before Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

THE necessity for an instrument of this character was shown during our recent experiments to ascertain the value of radium as a factor in the treatment of lesions of the urinary bladder, especially the various forms of vesical papillomata. A continued study of the physics of radium, when used as a therapeutic agent, has added to our knowledge of the subject in such a degree that we are now able to understand certain results obtained, as well as the inability to obtain results, in certain cases during other experiments of the past years. It has been demonstrated that to effect the destruction of a new growth, or even to effect an alterative change in its cell structure, it is of vital importance that the radium rays must penetrate every portion of the diseased area and it is very probably due to this one reason alone that many failures have followed the use of radium in the treatment of widespread malignant



lesions and multiple metastases. In using the universal glass tubes now in general use, containing ten, twenty-five, fifty or more mgs. of radium element, one is much surprised, by actual experiment to find what a relatively small area is covered by the concentrated rays which cause the actual cell change—although the secondary (and weaker) rays cover a considerable expanse. To better illustrate my meaning allow me to show you this radiograph, taken with fifty mgs. of radium element. The dark shadows at the edge of the plate are caused by its being covered with lead foil, showing that the rays do not penetrate it and illustrating how the surrounding healthy skin may be protected during the use of radium on superficial areas; you will notice that the body of the plate has been affected (and this effect would probably be found to cover an area several times the size of this plate, gradually shading off at the periphery). The rays have been focused upon three perforated shot in the centre of the plate and you will notice that their most intensive action is limited to an area which might be covered by a silver half dollar, as shown by the high light. The facts here demonstrated have led us to believe that it would be necessary to have an applicator cystoscope by which the radium capsule could be introduced under direct vision and held in accurate opposition with the lesion under treatment. Ashcraft's instrument is the outcome of these deductions and results have proved to us the soundness of the theory and the value of the practice. It must be understood, however, that we are now speaking of lesions of the urinary bladder which are small in area and can be readily located by the cystoscope, for in widespread papillomatous areas or carcinomatous lesions involving the base of the bladder, and in those involving the prostate it is, of course, necessary to do a preliminary cystotomy, in which case the radium in its usual container may be packed directly against the area to be treated by actual vision through the supra-pubic wound.

Another very necessary point to consider is the absorption and filtration of these rays. In any location it is imperative to screen out the alpha, or soft ray, which causes destruction of healthy tissue and, when the remaining rays can be brought into direct contact with the atypical cells, this is all that is necessary, being accomplished by the use of a screen of from .5 to .1 m.m. of silver, but if normal tissue interpose between the applicator and the lesion then additional screens of brass

and rubber must be used, thus taking advantage of the greater penetrability of the third, or gamma ray, when used alone. In other words, taking the subject under consideration as an example—if the radium container can be brought into direct contact with a bladder growth a single screen of silver is used, whereas if the growth should be on the anterior bladder wall and for some reason it should be advisable to treat it through the abdominal wall the extra screening would become necessary to obtain the desired result.

The length of treatment, by this method, of intra-vesical growths depends upon the size and character of the condition and the amount of radium available, so it is impossible to give any hard and fast rule. For these experiments we have used fifty mgs. of radium element and the length of application has been governed to a great extent by the ability of the bladder and urethra to accommodate the inlying instrument; from one-half to one hour sittings being the rule. These applications have been repeated as necessary until some positive tissue change could be noted in the growth and then discontinued, as we have found such changes to continue for a considerable time after the exposures have been stopped. In no case has there been more than 1,500 mg. hours used.

We can say that in vesical papillomata, where the area of disease could be entirely covered by the intensive radium rays, there has been a cessation of hemorrhage and a definite change in growth structure. In some cases the growth apparently disappeared. In other cases of wide-spread and degenerating papilloma, in which removal by operation was found necessary, the site of the lesion was exposed to repeated radiations and, so far, there has been no recurrence. These results, however, while very encouraging are simply immediate, the experiments extending over the past ten months only.

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CONGENITAL DEPRESSIONS, SINUSES AND CYSTS OCCURRING IN THE SACROCOCCYGEAL REGION.—McNealy in a brief paper discusses the depressions, sinuses and cysts of congenital origin, which are found over the coccyx or the lower part of the sacrum. He sums up the various theories as to their formation and describes their pathology and treatment. A very complete list of references is appended.

As nearly all of his cases had been previously operated upon, the author recommends a thorough examination of all fistulæ and cysts occurring in this region. If any trace of epithelial tract is left a cure cannot be expected. —*Surgery, Gynecology & Obstetrics*, December, 1919.

## EDITORIAL

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### COMPULSORY HEALTH INSURANCE—THE NEW YORK LAW.

NOTHING before has so definitely called attention to the necessity for the strongest possible active medical organization as has the present agitation for compulsory health insurance.

If the medical clauses of such proposed legislation are to be fair and just to physicians, pressure that is worth while must be brought to bear upon the members of the legislative bodies. This can be done in two ways, by an active working committee at the sessions of the legislature, and by individual influence with the legislators at their homes. Money and willing workers are required, individual effort alone will accomplish but little.

In Pennsylvania, the Medical Legislative Conference, a committee composed of equal numbers of the three schools of medicine, was a potent factor at Harrisburg during the last session of the Legislature in watching and controlling medical legislation, and the experience gained will be of great value in their continued work at the next session two years hence, when it is practically certain that a bill for compulsory health insurance will be introduced and pushed; this year the subject was referred back to the Commission for further investigation and report.

Physicians are notoriously poor politicians, and fail to realize that the game of politics is played in practically every bill passed in a State Legislature, no matter how meritorious the bill may be, and this does not mean merely that political party lines are drawn, but the "give and take" of politics, and every measure introduced must be carefully watched in its progress through committees and through both houses of the legislature.

In New York, the Davenport-Donahue bill for Compulsory Health Insurance, passed the Senate in March, 1919, and will be pushed before the lower House of Assembly this



winter. As this bill in its general outline represents those that will be introduced in the legislatures of other States a little study of it will be of interest. It proposes to compel every employe of the State of New York, about 4,000,000, to be a member of his or her neighborhood fund, with the exception of agricultural laborers, domestics, officers and managers, State and Government employes. It proposes to furnish them when ill with medical care, drugs and nursing, with dental work and with care during maternity of their wives, in addition to furnishing a certain cash sick benefit weekly, and a death benefit of \$100. The cost of this is to be divided equally between the employes and the employers. The administration of the act is to be in the hands of an Industrial Commission with a physician at its head. The State is to be divided into funds (or groups) of about 5,000, making about 800 funds, each to be administered separately, but under the Commission, with local physicians and nurses and dentists for each fund. The fees for medical services and all other service to be regulated by the Commission; the following is quoted from the bill: "The conditions of medical service and the rates and methods of compensation for physicians shall be fixed by the Industrial Commission."

The support of this bill, and the same is true in other States, comes from the labor unions, including the American Federation of Labor, who easily find willing politicians to back them up, for many reasons, including the votes of the labor class, and the vision of numerous small positions politically controlled.

The Benefactor-Foundations are also part of the force backing these bills; their joy is that of busybody sociological investigation, given plausible force because conducted by college-bred men and women who make professional philanthropy their means of livelihood.

If this bill passes it will be a vicious enactment, as it is decidedly class legislation. There are many glaring faults to this bill. No adequate provision is made for the enormous cost of its administration, and a deficit is sure to result from this experiment: physical examination of employes is explicitly waived so that the constitutionally incurable must be carried by this insurance precisely as the man of ordinary health; the self-employed (such as those who have little shops of their own) cannot join; no provision is made for the sick care of

the unemployed poor or the disabled or the sick aged, so that it will not in any way relieve or lessen the support necessary for the State or the public to provide for these classes of sick people.

The proponents of this bill do not submit estimates of its probable cost, except that it will cost each employe at least three and one-half cents of every dollar he earns, and they admit that it must of need be an experiment and open to future amendment. They ask for constructive amendments to be submitted by the medical profession.

There could be only one set of amendments to such a bill which could be of possible benefit to physicians, such as would assure justice to the medical profession, by securing adequate compensation for medical services and the right of a patient to choose his own medical adviser.

It is estimated that each employe averages nine days of illness annually, and that the cost of such insurance will be to the employes from three to seven cents on each dollar earned. The workingmen, especially those having no illness, will soon tire of a deduction of 7 per cent. from their pay envelopes, while the employer is sure to add his part of the cost to his overhead expense, as is being done with the cost of Workmen's Compensation Insurance premiums, and it will then be borne by the ultimate consumer—the public.

This bill cannot do what it proposes to arrange for without a tremendous deficit, estimated by the opponents at over \$90,000,000 annually, and for this very reason must be a failure as an economic measure. This deficit will, of course, have to be met by taxation. Such legislation should not be altruistic at all, but if classed as such, and the large extra expense put on the State passed on to the taxpayers, it is extremely doubtful if such a scheme for health insurance is in any way superior to the present State aid given through other agencies—hospitals, dispensaries, and the local aid societies, nor can one visualize a possibility of reducing or abolishing these present agencies for the relief of distress of illness and poverty by such proposed legislation.

No investigations by commissions have as yet proven anything conclusive except one fact—that the laboring class (for whom such legislation is intended) fail to protect themselves and their families through the agencies now open to them from the dire results of illness and its enforced idleness and from

the poverty of old age. The laboring class rarely save any money, lack thrift and when they become ill soon become a burden to others and must be given some form of aid, but so far no practical solution has been presented.

In studying the probable effect of such proposed legislation on medicine the writer fears a lowering of the Science and Art of Medicine, and that medical education will come to a standstill. Such a law can only be administered at the expense of the doctor's income, and the restriction of the field of private practice. Medical services will be underpaid and the doctors will be discontented as they now are in England, where there is in formation a union of medical men for their own protection from the injustice of their Compulsory Health Insurance Act.

It means the destruction of the personal relation between the patient and his physician by such contract practice and the elimination of individual interest and efficiency. There will follow a reduction of the practitioner's interest in science to a negligible quantity, and a deplorable check to the advance of medical education. Medicine will cease to be a profession and become a trade. The scientific laboratory and research work will be in the hands of the few appointed by those in political control, and the work of the general practitioners parcelled out by favor. How will this accrue in any way to the benefit of general humanity, and as a health protective measure such enactment must surely fall below the fairly efficient systems now in vogue.

The writer wishes it to be distinctly understood that he favors health insurance for employes in a limited form, but not compulsory, rather let it be voluntary on the part of the employes, and absolutely just to the medical profession. If health insurance be a good thing, a wise measure for the general public, by all means let us not oppose it, but to be such, it must give JUSTICE to all. Let medical men be alert to the conditions facing them for such a law will inevitably impose injustice upon them; let us get in control of the fee schedules and all the medical clauses of such bills.

WM. M. HILLEGAS.



### THE CLAIMS OF THE COUNTY MEDICAL SOCIETY.

THE factors included in the organization of the medical profession are the journals, the colleges, and the medical societies. The latter comprise national, state and county associations as well as a number of combined social and scientific bodies, with limited membership, generally classed as medical clubs. The members of the latter are usually bound together by social rather than by medical ties. While national and state societies constitute the most conspicuous parts of the medical organization, they are by no means as important as the local organizations by reason of their lack of knowledge of topographic conditions, and, therefore, of inability to govern them. Their numerical strength and their versatile and able membership are always recruited from the smaller organizations without which they would be helpless. With their large and widely scattered membership, they are seldom capable of doing as much for the county society as the county society can do for them. This being the case, one of their first duties is the fostering of every rule of procedure that tends to the prosperity of the latter. To this end, state societies should accept as members only such physicians as have already joined and are in good standing in their respective counties. Neglect of this provision not infrequently makes the larger organization ridiculous as instance the times when physicians who have but little or no standing at home, have succeeded in creating an impression abroad to which they are not entitled. To adopt it at once dignifies the county society as of initial importance, and specifically indicates to the young physician, the direction which he must take for his first society affiliations. If the young member gets "the county society habit" early in life and keeps it up, he learns the value of the acquaintances made therein. He learns of the activities higher up, and his environment should, if it does not do so, encourage him to take on state and national membership.

Unfortunately, county societies the country over have not enjoyed the prosperity to which they are entitled. Whatever the drawbacks may be, these should be overlooked in the obvious advantages of membership. These include the knowledge gained from scientific papers and the discussions thereon. The members having, as a rule, a close personal relationship, discussion is likely to be free, and, therefore, more highly educa-

tional than elsewhere. Membership in a society gives standing to a physician in his community, a standing moreover that has decidedly practical aspects. We can adduce no better example than that furnished during the late war, when all applicants for medical commissions in the army and navy were obliged to present their organization standing as part of their evidence of fitness. The larger county societies also provide measures for the legal defence of their members, thus affording a sense of professional security not otherwise obtainable.

The county society understands local conditions thoroughly, and knows best how to meet emergencies of medical character. It constitutes the best medium for the education of the public in matters of hygiene and sanitation.

The county society is a training school for the national and state organizations. Men who have attempted to take serious part in the latter without preparatory local training seldom succeed in obtaining more than a meteoric career. We may well take example from the political world, in which organization develops to perfection. The man begins in the division, and works his way up step by step until he becomes a factor in national conventions.

Recent events have impelled us to make this plea for the county society. Within the past month, the Philadelphia County Medical Society started a drive to obtain 1600 new members, and its membership committee decided that a fruitful field would be the homœopathic physicians of Philadelphia. Circular letters, and phone and personal solicitation became quite general. Such a move appealing as it did to our members individually must necessarily weaken interest in the homœopathic society, in fact endangering the very existence of the latter. Pennsylvania has a strong State Homœopathic Society. As well organized as it is, it could not stand, if a county society of the dignity of that of Philadelphia should be weakened. The existence of our college, though a national institution, would be threatened. The period was all the more dangerous, too. It was not surprising, therefore, that the number of physicians who turned out to consider the situation should be an unusually large one. It is not surprising that the resolutions which we publish in our news pages should have received an overwhelmingly favorable vote.

Reference in the resolutions is made to the undignified character of the campaign on the part of the Philadelphia

County Society. The term "undignified" related to the special method of securing new members. Form letters were sent to all homœopathic physicians in Philadelphia as individuals. It was, furthermore, stated that it was not intended to weaken the Homœopathic Medical Society. The method, it was held, was perfectly comparable with a "drive" on the part of one corporation to secure the employes of another without first consulting the directorate of the latter for the purpose of securing consent. In other words, it attempted to deal with the individuals rather than with the organization. The method was rather tersely and truthfully described as "sniping" by one of the debaters on the resolutions.

As we look over the medical organization of our school throughout the United States, we regret to note that our county organization is inherently weak, New York, Pennsylvania and Ohio have within their confines over half the homœopathic county medical societies of the country. A big state like Illinois has but one such society, that in Chicago. It boasts, however, of a district body, the Homœopathic Medical Society of Central Illinois. There are other large states no better provided. If our school is to become stronger, if our hospitals and colleges are to be supported, we must make a drive for new county societies. Never mind the state and national organizations; the organized counties will take care of them and give them prosperity.

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#### THE PLACE OF HOMŒOPATHY IN MODERN THERAPEUTICS.

THE treatment of disease according to the homœopathic method is based upon the law of similars enunciated by Hahnemann in his *Organon of the Art of Healing* which he expressed by the formula "*Similia Similibus Curentur.*" There has been much arguing both pro and con as to whether this formula represents a law of cure or whether it is only a rule of practice. This question is of minor importance, however, and is not essential to an understanding of the principles of homœopathic practice. The latter is based entirely upon the homœopathic materia medica which has been developed from studies of the effect of drugs upon healthy individuals, the symptoms induced by the ingestion of the various drugs being carefully noted and classified and thus a more or less complete



symptomatology of each drug being obtained. This method of study was designated by Hahnemann as "drug proving." The homœopathic materia medica also includes in its symptomatology the pathological effects of drugs observed in animal experiments and in human beings who have been poisoned by such drugs whenever these data have been available. In this manner the pathological action of drugs has been learned and the homœopathic relationship of certain drugs to certain diseases has been established. Again, some of the symptoms which have crept into the materia medica are entirely empirical; their therapeutic usefulness has been established by clinical experience. No claim is made that such symptoms always indicate homœopathic drug action and we are fully aware of the fact that the homœopathic materia medica needs a re-proving of many of its drugs. However, these empirical, or "clinical" symptoms should be accepted for what they are worth and not used as an argument against the validity of the homœopathic method.

The isopathic principle has become a most important factor in modern therapeutics; this is especially seen in the strides made by vaccine therapy in recent years. The cure of anaphylactic conditions such as hay-fever and asthma by the use of foreign proteins for the purpose of de-sensitization is another example of isopathy. This principle has also been applied to the cure of poison ivy dermatitis with the tincture of rhus toxicodendron by Schamberg (*Jour. Am. Med. Assn.*, Oct. 18, 1919). While these isopathic methods are, strictly speaking, not homœopathic, still they embody the same idea of the use of a single remedial agent administered in small doses for the purpose of bringing about a systematic curative reaction.

In the treatment of the sick all accepted therapeutic methods have their place. Purely physiological effects such as can be obtained from the administration of strychnia, digitalis and the bromids are needed in certain instances. Palliatives are frequently called for and are necessary adjuvants to the armamentarium of the physician. Specifics also occupy their proper place in medicine, notably quinine in malaria and mercury in syphilis. The former is an example of chemotherapy; the latter is a striking example of *similia similibus curentur*. The symptoms induced by small doses of mercury in individuals with an idiosyncrasy to this drug and the pathological manifestations of chronic mercurial poisoning present a simi-

larity to many of the symptoms of syphilis which cannot be explained as a mere coincidence.

DOSAGE.—The history of the homœopathic dose is given by Richard Hughes in his *Manual of Therapeutics* as follows: "When Hahnemann first began to prescribe medicines according to the rule '*similia similibus*,' he gave them in the usual quantities. It is not surprising that his patient's symptoms, even though ultimately removed, were often in the first instance severely aggravated. So Hahnemann reduced his dose accordingly. At what stage of this reduction he found that fractional quantities of a smallness hitherto undreamt of exercised a potent influence, I cannot say. But once satisfied of the power of infinitesimals, he adopted them with enthusiasm as a part of the new system of medicine he was inaugurating."

For a long time Hahnemann's opponents looked upon his infinitesimal doses as scientifically undemonstrable and, therefore, unworthy of any serious consideration. We have learned in recent years, however, that a number of substances exert their specific effect in doses which are practically inconceivable and too small for demonstration by ordinary chemical or physical tests. The internal secretions and vitamins belong notably to this group. Granting, however, the possibility of the action of drugs in infinitesimal doses, still there is no necessity for the employment of infinitesimal doses in order to practice homœopathy. The dose in which the remedy is used is, after all, not the principle upon which homœopathy is based. Hahnemann's original intent in recommending smaller doses than the usual physiological one was to avoid the production of a medicinal aggravation of the symptoms present. Thus, while small doses of ipecac will relieve certain forms of vomiting, a full dose would aggravate the same.

To the beginner in homœopathy and to those not in sympathy with the theory of drug attenuation small doses of the tincture or the lower dilutions and triturations are recommended. Let the dose fall just short of producing a medicinal aggravation and if the remedy is homœopathically indicated a curative effect will follow. Accordingly, the liquid remedies, excepting the very poisonous ones, may be administered in doses of one or two drops of the first or second decimal dilution and repeated every two hours or more frequently, if necessary, in acute conditions. In young infants the use of the third decimal dilutions is preferable. When using insoluble sub-

stances such as the carbonate of calcium or phosphate of iron, the third decimal trituration should be employed. The interesting experiments conducted by Dr. Percy Wilde and published in the *Journal of the British Homœopathic Medical Society*, January, 1902, demonstrate that the process of trituration induces changes in the physical property of the substances thus treated, converting apparently inert substances into a state in which they can enter into chemical combination with certain cells of the human economy for which they may possess a selective affinity.

C. S. R.

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### OUR HEROES.

THE medical corps of the Army is non-combative. Those who volunteered in this branch of the service, did so for the good they could do their fellow men. "He is good that does good to others. If he suffers for the good he does, he is better still; and if he suffers from them to whom he did good, he is arrived at that height of goodness that nothing but an increase of his suffering can add to it. If it proves his death, his virtue is at its summit; it is heroism complete." This quotation is used the better to express ourselves in our feeling toward the Pennsylvania homœopaths who died while serving in our Army. Public opinion and the applause of men make a fame less permanent than that which is founded on labors which promise the happiness of mankind.

Losing such men seemed at first a great loss; but time revealed the remedial force that underlies the fact. Their deaths, which seemed but privation, assume the aspect of a guide; for death commonly operates revolutions in our way of life. So it is that such misfortunes have a compensation which is made apparent only after an interval of time.

The indifferent may pass before their last resting places and pause with a shrug of pity; but before us their memories shine. We honor them for their silent lessons; we cherish their examples. Each reflected sufficiently upon the seriousness of such a service and entered with full consent of his will. Those who distinguished themselves did so because they were great enough to grasp the opportunity when it presented itself. Those who did not distinguish themselves, simply never had



the opportunity; but had that greatness most commonly found among the multitude whose names are never heard.

Belated though these thoughts may seem, it is always fitting to remember the dead. Their sacrifices are impressed upon us now, more than ever, since all have returned to answer the roll-call except our heroes:

WILLIAM J. MARTIN,  
GEORGE W. H. CONRAD,  
ROBERT H. MURDOCK,  
HUGH T. RYAN,  
RICHARD FRANKLIN HILL,  
WARREN A. VAN DERVEER,  
JOHN LEE FISHER.

J. G. W.

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#### HOMŒOPATHIC PHYSICIANS AND THE ALCOHOL SUPPLY.

WE have just received word through the energetic chairman of the Committee on Pharmacopœia, American Institute of Homœopathy, that he has received a letter from Mr. H. M. Gaylord, Deputy Federal Prohibition Commissioner at Washington, D. C., as follows:

"In reply to your letter of the 17th inst. asking whether conclusion has been reached that homœopathic physicians will be allowed to purchase from 12 to 15 gallons of alcohol, including dilutions and potencies, within a year without bonding, you are advised that it is not intended to specify any definite amount, but that applications for amounts up to 15 gallons will be considered as legitimate quantities. It is not expected that complete regulations will be published before the first week in January, and, therefore, I am unable to advise you more definitely."

The above settles a very serious question involving the practice of homœopathic physicians. Credit should be given to Dr. Carmichael and his colleagues who have persisted in their efforts to overcome the adverse ruling previously made by the Revenue Department at Washington.

## GLEANINGS

### MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

INFLUENZA AND TUBERCULOSIS.—A survey of the available literature and his own experience have led Maurice Fishberg to believe that influenza has no etiological relation to tuberculosis and cannot be considered as a reactivator of dormant lesion. Tuberculosis patients are not unusually susceptible to influenza, nor is the latter disease more severe in them. He has not observed pulmonary tuberculosis assume an acute, progressive course after influenza. Vital statistics and sanatorium reports do not disclose that in the wake of the recent influenza epidemic there has been an increased mortality from tuberculosis nor that the number of tuberculosis patients has increased. The pulmonary sequelae of influenza are quite generally non-tuberculous and do not require tuberculosis treatment.—*American Review of Tuberculosis*, November, 1919.

EXPERIMENTS TO DISCLOSE THE FATE OF BACTERIA INTRODUCED INTO THE UPPER AIR PASSAGES.—From the Medical Clinic of the Johns Hopkins Hospital, Bloomfield reports a series of interesting experiments, by which he aimed to study the mechanism used by the mouth, nose and throat to rid themselves of bacteria. Human beings were used in the experiments; and solid masses of cultures of *sarcinae lutea* were swabbed on the tongue, nasal mucosa and tonsils of various individuals. At various intervals thereafter cultures were made of the various local secretions and from scrapings of the swabbed parts.

The germs disappeared from the tongue very rapidly. After ten minutes only a few colonies could be recovered; and none at the end of an hour. On the nasal mucosa the bacteria persisted longer, yet in only one of five cases could a few colonies be recovered after twenty-four hours. Introduced into tonsillar crypts, the organisms could no longer be recovered after twenty-four hours, and in two out of four cases they had disappeared after an hour.

The author then tested in vitro the direct action of the mouth secretions and saliva on the *sarcinae* and also made experiments to determine the influence of mechanical factors. As a result of these, he concludes that, so far as this particular micro-organism is concerned, saliva exerts a rapid bactericidal effect upon it and that this effect is independent of the bacteria normally present in the saliva.—*Johns Hopkins Hospital Bulletin*, Nov. 1919.

SYPHILITIC FEVER.—Candido Ferreira (*Brazil-Medico*, 1919, vol. xxiii, p. 97) relates a case as follows: Male, 26 years old, had a series of venereal diseases extending over several years, precise time of syphilitic infection, if any, unknown. On the occasion of a headache he was found to give a Wassermann negative. He was subject to attacks of angina, and in 1918, about six years after his diagnostic test, he developed a sore throat with

some temperature rise and a general reaction. The diagnosis was gripe, the pandemic having not yet run its course. Fever and headache were very persistent and lasted some weeks without any relief from coal-tar derivatives. The angina had long ago subsided. Examined from head to heels nothing could be discovered except a somewhat enlarged liver. An eminent colleague then diagnosticated a possible abscess of the liver with enlargement of the same and an intermittent fever. The blood count was not that of a suppurative process. All possible affections were considered, as acute endocarditis, neoplasm, tuberculosis, malaria, typhoid and paratyphoid fever, suppurative pyelophlebitis and influenza sequelae, all of which were seemingly excluded. A test of an injection of neosalvarsan was followed with a rise of temperature with a positive blood test. The originally negative Wassermanns with the lack of a definite history of syphilitic infection had thrown the medical men off their guard (along with the presence of the influenza pandemic). The history pointed to gonorrhea and chancroids only. In about one month all of the symptoms had disappeared, including the enlarged liver.—*American Journal of Syphilis*, Oct. 1919.

NEGLECTING THE PULSE.—The sphygmomanometer having been brought into question it may be stated that the instrument is not an unqualified boon. It does truly furnish a delicate and precise test that enhances the exactness and certainty in the determination of abnormal conditions and in the diagnosis of disease processes. It is an acquisition of real value, and its importance in the field of investigation of body states and body functions should not be underestimated. A flagrant misuse, however, is its indiscriminate, ostentatious, ominous employment among sick people. A possible evil is routine, mechanical, absolute, servile dependence upon it to the exclusion or neglect of the study of the pulse by palpation. To the deft, keen physician the pulse tells much more than the sphygmomanometer can tell. Says Galen: "the science of the pulse is difficult; it exacts of him who wishes to acquire it a great attention of mind and an extraordinary talent for observation." This is eminently true. And although Galen authorized undue, even preposterous, enumerations and classifications and even clearly verged upon the fanciful and whimsical extremes reached by the Chinese savants, yet nevertheless the pulse does show many phases and many combinations. In fact no two pulses are exactly alike.—*American Medicine*, November, 1919.

DIFFERENTIAL DIAGNOSIS IN NERVOUS SYPHILIS.—(W. A. Jones, Minneapolis, *Journal-Lancet*, 1919, vol. xxxix, p. 342.) A physical examination usually shows some of the cardinal differential points. In syphilis the pupils are usually different in size and in form; and a pupil that is irregular, elliptical or larger than its fellow, is very suggestive of a syphilitic origin. Some one has said that the left pupil is more apt to be larger than the right. When a fixed pupil exists and the knee jerks are obtainable, or are obtained only with great difficulty or by reinforcement, one must consider immediately the possibility of a developing tabes or posterior spinal sclerosis. The usual methods of diagnosing tabes will clear up any uncertainty that one may entertain. But again, if this condition is associated with alcoholism, with its stupor and mental phases, due to a "wet brain," further investigation may be needed to determine the relative value of the two disorders. One precaution may be sounded as to the value of the blood Wassermann and the spinal fluid Wassermann. One must be prepared for an occasional uncertain



diagnosis, for in both of these diseases (alcoholism and nervous syphilis) there is a tremor, usually of the extremities or of the tongue, and the safest method of differentiation is a spinal puncture with notation of the pressure of the spinal fluid, and the reaction obtained for syphilis, as well as a positive globulin and excess albumin. When the neurologic symptoms predominate, however, and there is a persistent tremor or a persistent special defect shown by the alteration of the reflexes and particularly the defective reflex in the pupil, the probabilities are that syphilis is the fundamental cause of the disease.—*American Journal of Syphilis*, October, 1919.

**SYPHILIS AND IRREGULARITY OF THE PUPIL.**—Dujardin and Raskin (*Annal d'Oculistique*, January 1919, p. 89) from the study of a series of cases of irregularity of the pupil, conclude that such an irregularity is a very frequent symptom in syphilitic infection. It is most common in the secondary stage; from thence onward it tends to become complicated with other disturbances of the pupil, although irregularity may be the sole pupillary phenomenon in advanced syphilis. Reciprocally, irregularity of the pupil in at least 70 per cent. of the cases is of syphilitic origin. Accordingly every case of irregularity of the pupil should be examined serologically and if this is negative, by lumbar puncture.

**LATER STAGES OF SO-CALLED WAR NEPHRITIS.**—Much has been written concerning war nephritis, but it remains for Howard to review the later phases of the disease. His summary is as follows:

1. Thirty-seven cases of nephritis contracted overseas were studied at a period averaging four months.
2. One-half have recovered, one-quarter have developed chronic nephritis (with one death), one-quarter still have nephritis but may ultimately recover.
3. Persisting albuminuria is common but is considered of but little prognostic significance.
4. Polyuria is not uncommon, and when it occurs is a valuable sign.
5. Relative increase of night urine is practically constant in active cases and is not infrequently the only anomaly in the apparently recovered.
6. Blood urea above 35 mg. per 100 c. c. usually meant nephritis, as proved by other factors. Normal readings were frequently found in active cases.
7. Moderate reductions of phenolphthalein output is not an uncommon finding in those patients who have apparently recovered.
8. An elevated blood pressure proved the most reliable single sign.
9. A moderate degree of anemia is extremely common.

—*American Journal of Medical Sciences*, Dec., 1919.

**LETHARGIC ENCEPHALITIS.**—Ernest W. Goodpasture reviews the present status of this new disease. Encephalitis may occur as a complication in any acute infection. With encephalitis, an elastic term, diffuse brain infection is expected, and with it the naturally outstanding feature of lethargy. In nine out of ten cases described here there was a definite febrile period, either preceding or concomitant, including "bad cold," mumps, some form of bronchopneumonia, and in one a possible paratyphoid-B. The facilities here were such as to afford only a clinical and a rather limited laboratory study of these cases. There was eosinophilia in the blood and a lymphocytic spinal fluid in most instances, and what bacteriologic examinations were made proved negative. This much is true, that while the majority of these cases resemble other well known diseases of the central nervous system, they were atypical in some form, either in onset, clinical course, or outcome; but

clinically they were encephalitis with lethargy. The study, therefore, of these cases, while bearing in mind the possibility of their being distinct infectious diseases of the nervous system, which may escape detection because of a general similarity in their clinical manifestations to well recognized entities, does not aid in establishing lethargic encephalitis as a definite clinical entity.—*American Journal of the Medical Sciences*, Dec., 1919.

#### DERMATOLOGY.

Conducted by RALPH BERNSTEIN, M. D.

**PAINFUL NODULAR GROWTH OF THE EAR.**—In 1915 Winkler reported having seen eight cases of a condition which he called “chondrodermatitis nodularis chronica helicus.” A group of four cases is now reported by Foerster which are apparently identical with those described by Winkler. The growths make their appearance suddenly without a history of preceding injury. They reach their maximum size in a few weeks and then remain stationary. In one of the cases the growth made its appearance when the patient was twenty-one years of age, and had remained unchanged for a period of ten years. In the other cases reported the growths had been present for eight, twelve and eighteen months, and the patients were fifty-six, sixty-two, and fifty-one years of age respectively and were all males.

The lesion is painful on pressure from the beginning and it is the pain which usually attracts attention to the lesion. The growths are single, ovoid, well defined, rose red in color, and range from 3 to 4 mm. in their longest diameter. They are imbedded in the skin, but only in one instance was the growth attached to the underlying cartilage. The growth has either a flat top or is slightly convex, with a sloping margin, and there is a shallow depression in the center which is filled with an adherent scale. The skin surrounding the base is normal in appearance and shows no evidence of seborrhoeic change.

That there appears to be no malignant tendency is borne out by the fact that one of these growths remained unchanged for a period of ten years.

Microscopic examination of one of these growths showed a diffuse inflammatory and degenerative process of the corium associated with considerable epithelial hypertrophy. The rete showed marked acanthosis, particularly at the center of the lesion where the pegs were much lengthened and broadened. There were aggregations of rete cells in the cutis which were evidently snared off pegs. There was no evidence of malignant change. The entire corium showed a generalized oedema with dilatation of the lymph spaces, thickening of the blood vessels and perivascular infiltration. This consisted of round cells and epithelioid cells with a few scattered plasma cells. The collagen showed a granular degeneration and the elastic tissue was also degenerated. A further and more complete histologic study will be necessary before it will be possible to reach a definite conclusion as to the nature of the growth.

Treatment with Roentgen rays resulted in the complete disappearance of one lesion, had no effect on another, and was followed by recurrence in a third case after eight weeks. The galvanocautery, electrolysis, or solidified carbon dioxide would, because of their destructive action, seem to be preferable methods of treatment.—*Journ. Cut. Dis.*

**LEPER COLONY IN ABYSSINIA.**—Innes made an interesting study of the

condition, habits of life and infectivity of a colony of twenty-six lepers comprised of nine men and seventeen women.

He found that the average duration of the disease was thirteen years; the average residence in the colony being six years. In four cases husband and wife have both been lepers, and in all of these couples one of each couple was leprous many years before the other became so.

He found no record of any child having become a leper, although all of the women had children before entering the colony. However, all the children died young and there is record of only one grandchild.

Innes particularly describes the case of a woman aged thirty who had suffered from the disease for ten years. This woman had given birth to two children while in the colony. The fathers were lepers and had since died. The first child was born healthy and lived for two years, when it died, presumably from malaria. The second was still-born.

According to Innes, the first symptoms vary considerably. Twelve of the cases began with violent itching; three had pains in the bones; five had watering of the eyes; seven had blisters with or without itching; and two had red spots. At the time of the report all of the patients had more or less bone pain, and two women and seven men complained that it was so intense they could not sleep. One tubercular case complained of his nose being very sore, and one woman, who was blind in one eye, due to accident and not to leprosy, said that the blind eye was very sore. All cases presented some degree of leukoderma, except three which were purely nodular cases. Two had atrophic bullae on the stump of the hand which were painless, and all whose feet were affected had small ulcers under the great and little toes. In a majority of the cases the feet are badly mutilated and one woman was unable to walk.—*Brit. Jour. Dermatol.*

**RAPIDLY FATAL MYCOSIS FUNGOIDES.**—F. Parkes Weber reports a case of mycosis fungoides which was unusually rapid in the course it ran, and of which he made a careful study at autopsy. The patient was an unmarried woman fifty-three years of age. When admitted to the hospital she had an eruption principally on her trunk, which consisted of slightly raised discs or plaques which were red or purplish in color. There were also present fungating growths and large crateriform ulcers. The disease had commenced about five months prior to entrance to the hospital and the history of the case disclosed the further fact that some years prior to the patient's admission to the hospital she had been in a lunatic asylum. Upon her admittance to the asylum she was suffering from acute delirious mania, and later on suffered from auditory and visual hallucinations. On two occasions the Wassermann reaction was slightly positive, but it is quite probable that in cases of mycosis fungoides the Wassermann reaction is sometimes positive without there being any real syphilitic taint. There was no trace of albumin or sugar in the urine, and the liver, spleen and superficial lymphatics were not decidedly enlarged. The patient's temperature while in the hospital varied from 98° F. in the mornings to 102° F. in the evenings. Her appetite was unusually good. Much relief was gained from sitting or lying in a tepid bath for a great part of the day. No pronounced difference was evidenced as a result of arsenical treatment, and the use of tincture of perchloride of iron. There was a continuance of the septic pyrexia and the patient gradually became weaker and died. The autopsy disclosed nothing definite in viscera pathology except malignant endocarditis of the mitral valve and embolic infections of the spleen.—*Brit. Jour. Derm. and Syph.*



## GYNECOLOGY

Conducted by NORMAN S. BETTS, M. D.

PRACTICAL POINTS AND COMMON ERRORS IN THE TREATMENT OF STERILITY.—Reynolds, (*Journal of A. M. A.*, October 11, 1919) classifies sterility into those due to mistakes in the marital relation; to neglect or failure to appreciate sterility in the male; the subjection of innocent abnormalities to unnecessary and nonproductive operations, and failure to detect evident causes of sterility from lack of special training in microscopic examinations.

Amorous caressing without cohabitation, lack of synchronicity in the orgasms, withdrawal by the male, habitual excessive coitus, and psychological causes of failure to obtain the orgasm are cited as examples of mistakes in the marital relations. Most of these factors tend to produce chronic congestion of the female pelvic organs in which case glycerine depletion of the vagina will frequently break the vicious circle and restore normality. Merely psychological causes are quite common among women and may sometimes be dispelled by ascertaining the origin of a psychic impression of a distaste for coitus and giving appropriate advice.

In the author's experience the male has been involved in about 50 per cent. of all cases, and, moreover, the majority of male sterilities have been of nonspecific cause.

When the organs of a sterile woman show no gross abnormality she is usually advised to try some one of the time honored minor expedients and is dismissed with that advice; but when some gross and easily detected abnormality is found she is too frequently subjected to operation on the mere chance that that abnormality may be causative to the sterility. If performed in the absence of an exact knowledge of the causes and conditions that are involved, such an operation is naturally not adapted to their correction; and while it may occasionally yield results, it is worse than wasted in the other cases. Especially prominent among these useless operations are those for retroversion without recognition of one of the functional derangements of the ovaries which imply nonovulation, or of a pre-existing ante flexion from the existence of short anterior attachments of the cervix. Unnecessary and unsuccessful curettings are another extremely frequent element in the empiric treatment of sterility and when done without the correction of the shape of an underdeveloped cervix very often produce scar tissue about the angle of flexion which distinctly decreases the prospect of subsequent pregnancy. The use of stem pessaries is a far too frequent and very harmful expedient in the treatment of sterility. The author has never had a success with any other form of treatment after the unsuccessful use of the stem and has seen not a few salpingitides which apparently were referable to its use.

Biochemical vaginal hostility of bacterial origin, mechanical cervical hostility from inspissated mucus, tubal hostility without marked enlargement of the tubes, and ovaries which are nonovulating from retention of the follicles are frequent causes of sterility which seldom produce ill health or even gross lesions. The diagnosis of these conditions can be made only with the microscope. A complete examination includes a carefully taken history, thorough physical examination of the male and female sexual organs, which the author describes in detail, as well as chemical and microscopic examination of the sexual secretions of both man and wife, including their reaction upon each other.

**HYPERTENSION AT MENOPAUSE.**—Cummings, (*California State Journal of Medicine*, Oct. 1919) states that high blood pressure is very frequent at the time of the menopause. He believes that the blood pressure should be taken frequently at this time, especially if hot flashes and nervousness are present. Marked relief of these symptoms has been obtained by the use of bromides and extracts of glands of internal secretion.

**TREATMENT OF VAGINAL DISCHARGE.**—G. F. Chandler, (Am. Assoc. of Obstetricians and Gynecologists, Cincinnati, Sept. 15-17, 1919) treats ordinary vaginal discharges by the so-called dry method. Six treatments are given. The first three treatments consist of swabbing the cervical canal with pure carbolic acid and painting the entire vaginal wall with a weak solution of iodine, after which the vagina is packed with dry sterile gauze in sufficient quantity to straighten out all folds. The last three treatments consist of the application of a powder made of equal parts of stearate of zinc, starch and boric acid and packing the vagina with sterile gauze.

## PEDIATRICS

Conducted by C. SIGMUND RAUE, M. D.

Harold R. Mixsell, M. D., in *Archives of Pediatrics*, August 1919, gives the results of "Thick Cereal Feedings in Twelve Cases of Malnutrition in Infancy with Report of Two Typical Cases." The patients varied from 4 weeks to 6 months of age; were normal in every way but refused to gain weight on various high sugar, high fat or proprietary food formulæ.

"The stock formula on which these thick cereal babies were started was approximately 1 tablespoon of farina to 7 ounces of a 1 per cent. milk. To the entire formula about 3 per cent. of cane sugar was added." Later dextrimaltose was used. "All of this was cooked together for at least 30 minutes, or until the cereal was so tenacious and thick that it would barely fall off an inverted spoon." The author stresses the necessity of thoroughly cooking the mixture to prevent diarrhea from the high starch content.

"In every case there was a decided change for the better physically and a decided gain in weight." The author found that it was best to change back to a milk formula at the end of about 2 months, although one case was fed upon the cereal for 8 months with good results. Green vegetables and fruit juices, particularly orange juice, were added to the diet from time to time. Water in amounts up to 6 ounces, 3 times a day was also given.

Dr. Mixsell's conclusions are:

1. Thick cereal feedings are a valuable adjuvant in cases which will not gain.
2. Babies tolerate a high starch and sugar in this method of feeding.
3. For this reason high calories may be given.

**ACUTE NEPHRITIS IN CHILDHOOD.**—Lewis Webb Hill, M. D., (*Journal of the American Medical Association*, December 6, 1919.) Dr. Hill presents a brief exposition of his experience with acute nephritis in the Children's Hospital, Boston. Etiologically the vast majority of cases of this disease in children is due to micro-organisms or their toxins and the author believes that far more cases are secondary to tonsillitis than to scarlet fever. "It is quite characteristic of those cases secondary to tonsillitis that the nephritis does not appear during the period of sore throat and fever, but usually a week or so after the patient is up and around and apparently well."

Dr. Hill divides acute nephritis in children into two groups according to the clinical picture:

1. Acute Hemorrhagic Nephritis which is characterized by a very bloody urine containing very few casts. "The urine is not diminished in amount and there is usually no edema." The hematuria persists for six to twelve weeks and blood may often be found microscopically for several months. "The prognosis is, as a rule, good."

2. Acute Exudative Nephritis is accompanied by marked edema; scanty urine, during the acute stage, which contains a heavy sediment of disintegrated blood, a large amount of albumin and large numbers of granular or cellular casts. "The blood pressure is usually elevated, there may be headache and convulsions, and occasionally a patient dies in uremia." "Most patients recover and usually without the development of chronic nephritis."

As to the treatment the author says: "Drugs, with the exception of laxatives, (licorice powder) and cathartics, (magnesium sulphate), are of comparatively small value in the treatment of acute nephritis, and far more important is the general care of the patient, particularly as regards the diet and the water intake. 'The child should have not more than 2 grams of protein per kilogram of body weight. For practical purposes, in many cases, it is quite sufficient to omit meat, eggs, fish and meat soups from the diet, and to make it up of cream, milk, cereals, bread, potatoes, etc.'"

Salt. "In the cases without edema, it is quite sufficient to prohibit any salt cellar on the tray. In the edematous cases, the butter should be unsalted, and the bread, cereals and vegetables should be cooked without salt."

Water. "In the nonedematous cases no restriction of water is necessary. About 48 ounces of fluid a day should be taken. The edematous patients should take about 12 ounces of fluid daily. It is important to weigh these patients every day, as often there will be an increase in weight, due to water-logging, that is not apparent on the surface of the body."

Edebohls' operation "should not be considered except in extreme cases, when there is a large amount of edema present which will not respond to ordinary measures of treatment, or when the patient is in such a severe state of uremia or anuria that the prognosis is very bad."

"The child should not be allowed out of bed until the urinary sediment is practically free from blood." During convalescence Dr. Hill points out the danger of over-exertion and chilling of the body and the importance of guarding the patient against throat and respiratory infections as the occurrence of one of these conditions often results in an acute exacerbation of the nephritis.

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## UROLOGY.

Conducted by LEON T. ASHCRAFT, M. D.

NOTES ON DIAGNOSIS IN AFFECTIONS OF THE URINARY TRACT.—Paul (*Canadian Med. Assn. Journ.*, 1919, ix, 614) considers pain a very uncertain symptom. Often it is not present at all; and when it is, may be reflected to other portions of the body. When disturbances of urination are present, the best methods of investigations as to their source are by means of the cystoscope, the ureteral catheter, the endoscope and the x-ray. The kidney function test and careful urinalysis are also very important. One should trace the source of pus, blood or bacteria, if found. Catheter is due to a chronically infected kidney, and constitutes a form of urinary septicemia.



What is called commonly "cold in the bladder" is an exacerbation of a chronic colon-bacillus infection of the urethra. In searching for the cause of a mild, but persistent septicemia, one often neglects the prostate and seminal vesicles, where this cause might be found. Tuberculosis of the kidney does not produce symptoms until the lesions are connected with the urinary tract. This may take a long time. Increasing irritability of the bladder, increased frequency of urination and pain are the most common early symptoms. The diagnosis is determined by the cystoscope, the functional test, cultural methods, guinea pig inoculation, and the finding of the tubercle bacilli on microscopic examination.

**PROSTATIC CALCULI FROM THE ROENTGEN-RAY DIAGNOSTIC STAND-POINT.**—Hubney (*Am. Jour. Roentgenol.*, 1919, vi, 286) from a careful review of the literature on the subject, believes that prostatic calculi occur much more frequently than is generally thought, and that they should be differentiated from bladder- or deep urethral stones. While the condition may be confused with chronic prostatitis, it is possible to make a definite diagnosis by the x-ray. This will also often prevent unnecessary opening of the abdomen and bladder in many instances, because the stones can be expressed through the urethra. If a stone is removed by prostatic massage, one should take an x-ray picture afterwards in order to ascertain whether any more stones are left.

**CALCULI OF THE PROSTATE.**—Spittel (*Indian. Med. Gaz.*, 1919, ii, 255) reports three cases in young people—19, 20 and 35 years, respectively; although such cases usually occur in middle and old age. These stones may originate in three ways. They may be formed in the prostate, in pouches communicating with the prostatic urethra, or in the kidney or bladder. In the patient of nineteen years, the author believes that the two stones found had been formed first in the prostatic urethra. In this instance, he did a suprapubic operation; although the perineal route is usually the best to employ. In the second case, also, he used the suprapubic route; although he believes that the perineal route would have been better in this case. Twelve faceted stones were found in pouches communicating with the prostatic urethra. Perineal drainage was used. The third patient had had for years stricture and chronic infection, and the symptoms were thought to be due to these conditions. At operation, however, there were found a large number of small stones due to corpora amylacea.

**ROENTGENOGRAM THERAPY OF PROSTATIC HYPERTROPHY.**—Canovas (*Siglo med.*, 1919, lxvi, 433) believes that the more granular tissue predominates over connective in prostatic hypertrophy, the better will be the result from treatment with the x-ray. Of ten patients treated by him, four had previously had attacks of urinary retention. These had not returned a year afterwards. The treatment consisted in the application of hard roentgen rays, and this therapy resulted in a marked reduction of the amount of an adenomatous prostate within six months in most of the cases. The author believes that this method should be tried in every case of prostatic hypertrophy before resorting to operation.

**THE TREATMENT OF CHRONIC SEMINAL VESICULITIS.**—A. P. Martin (*Siglo med.*, 1919, lxvi, 356) states that the prostate is often operated on unnecessarily, when the trouble is really in the seminal vesicles; because the

symptoms in the vesicles are often masked. He reports seven cases treated by a method suggested by Thomas, of Philadelphia, which consists in injecting a silver solution into the deferent canal, in the direction of the outlet of the seminal vesicles into the posterior urethra. When the amount injected is not sufficient to excite the effort of the vesical musculature to expel it, the fluid will remain in the vesicle for a long time, especially if the vesicle has been emptied by massage. This makes its therapeutic effect greater than that of seminal vesiculotomy, and does away with operative traumatism.

**INTRAVENOUS INJECTIONS OF SALVARSAN INTO THE EXTERNAL JUGULAR VEIN.**—Oliver (*Urol. and Cut. Rev.*, Nov., 1919) in reporting two cases of this route of administration, states that he does not know of any previous case in which it was employed. In the first case, that of a man, the scar tissue resulting from a severe burn of both arms prevented the use of a vein in either arm for the injection. Arsphenamine and neo-arsphenamine were injected into the external jugular vein on several occasions, without any local reaction except a slight facial hyperemia and a feeling of warmth. The second patient was a woman, the veins in whose arms were not palpable with constriction, and in whom the external jugular vein was used for the injection of salvarsan a number of times without any untoward effect. The author has not yet employed this method with children, but thinks that it should be the method of choice in them, because the fatness of their arms hides their small veins. In making the injections into the external jugular, he allows about five minutes more time. The reactions have been identical with those observed when the median basilic vein was used. The external jugular is large and easily distended, but more care must be exercised in using it, because it has less supporting tissue than the veins of the arm, and because the skin and superficial fascia are more resistant in the neck than in the arm.

**THE PROBLEM OF MALE STERILITY, DUE TO OBSTRUCTIONS IN THE PELVIC PORTION OF THE VAS.**—Victor D. Lespinasse (*Urol. and Cut. Rev.*, Nov., 1919) has devised several operations for the correction of this condition. The first is the formation of an epididymo sac, or artificial spermatocele. This is for obstructions in the epididymis. When an attempt was made to make a sac out of the tunica vaginalis, failure was encountered, owing to adhesions between the perineal surface and the raw surface of the epididymis. To overcome this difficulty, skin was employed. Another difficulty encountered was hemorrhage, which formed a clot and ultimately sealed the tubules. By exercising extreme care in cutting through the epididymis capsule, so as first not to cut or tear any blood vessels, and secondly not to open the epididymal tube, this difficulty was obviated. Later, a piece about twice as long as the diameter of the tubule was removed, and success thus attained.

The second operation devised by the author is called intradermal transplantation of the vas. It is performed when the vas is dilated from retained secretions, and it is feasible to bring it up to the skin surface so that its contents may be easily aspirated. When the operation is done, the vas projects about one-half of its diameter, but the skin soon grows over it.

These two operations have been done clinically several times by the author. He has also devised a third, the implantation of the vas into the membranous urethra. This, however, he has never performed clinically. From a purely sexual standpoint, he considers this the best operation, because it would enable the patient to deposit the spermatozoa into the vagina himself.

## SURGERY

Conducted by J. DEAN ELLIOTT, M.D.

**DIAGNOSIS AND TREATMENT OF DISEASES OF THE GALL-BLADDER AND BILIARY DUCTS.**—Lyon makes a preliminary report on a new method of diagnosing and treating these diseases, based upon observations on 100 cases during the last two and one-half years.

By applying a 25 per cent. solution of magnesium sulphate in the duodenum through a tube he is enabled to overcome the sphincter of the common duct, cause contraction of the gall-bladder and thus drain the bladder and ducts of their bile. This bile is collected in sterile aspirating bottles and examined cytologically and bacteriologically. He believes that the first bile obtained, which is lighter yellow, usually transparent and much less mucoid than the later bile, is from the common duct. The next, believed to be bile stored up in the gall-bladder, is darker, more viscid and more concentrated and, in normal gall-bladders, remains transparent, but is more of a molasses yellow. The final bile collected is lighter yellow, thinner, usually transparent, is aspirated much more slowly and intermittently and is believed to be bile freshly secreted from the liver.

In pathologic states of the bile passages the appearance and the character of the bile is quite different from that described. The following types have been observed:

A. *Choledochitis*.—The bile is more viscid, with an excess of flaky mucus, is usually turbid and usually "off" color; cytologically, it contains pus cells enmeshed in mucus, epithelium and, occasionally, red blood corpuscles; bacteriologically, cultures may show pathogenic organisms.

B. *Cholecystitis*.—Without choledochitis, the first bile collected is relatively normal, grossly and cytologically and culturally does not contain pathogenic organisms. But the second bile is grossly pathologic; it is more viscid than normal gall-bladder bile; it is turbid, with a flaky or stringy mucus; cytologically, it will show inflammatory elements, pus, red blood cells (occasionally) and desquamated epithelium, and, bacteriologically, cultures will show pathogenic organisms. In some cases with pronounced catarrhal elements the cultures have been negative.

C. *Cholelithiasis*.—In addition to the evidence of cholecystitis, the bile, in two instances, contained a sediment that was gritty or sandlike in consistency, which was seen, microscopically, to be made up of bile salts. Once three small, faceted gall-stones were recovered, after the use of magnesium sulphate, from a patient who was afterward operated upon, in whose common duct were found one very large and several smaller stones.

In no instance has bile freshly secreted from the hepatic ducts given positive bacteriologic or cytologic findings suggestive of an infection involving or originating in the liver.

This method of direct access to the biliary apparatus opens up a new field of rational medical treatment for diseases of the gall-bladder and bile ducts, and in a paper soon to be published Lyon will report his therapeutic experiences of two and one-half years. Considerable success has been achieved in the treatment of cholecystitis, choledochitis, catarrhal jaundice and infective duodenitis by this method of direct medical drainage of the biliary apparatus, and direct disinfection of the duodenum and intestine by the use of various germicidal solutions.—*Jour. of the A. M. A.*, Sept. 27, 1919.



THE IMPORTANCE OF PHYSICAL THERAPY IN MILITARY AND CIVIL PRACTICE.—Commander Bainbridge believes that one of the most important lessons of the war is the great value of physio-therapy. Its application is not restricted to the wounded or victims of accidents, but it is necessary in the treatment of many other pathologic conditions and of various physical defects resulting from disease. Thus many men who were unable to undergo full training when admitted to the army were found to be suffering from conditions which could be cured by proper treatment, sometimes by operation, but more frequently by some form of physical therapy.

Much excellent surgical work was nullified, both from the military and economic standpoints, through lack of proper care during the period of convalescence. To overcome this the belligerents on both sides early organized hospitals and large centers of orthopedic surgery and functional re-education. The results can be gauged from the report of Dr. Camus, Chief of the French Service for Physical Treatment, that the improvement due to the various forms of this treatment, judged from the function measured on arrival and before discharge, showed an average mean gain of 30 per cent. In a typical British military hospital the various forms of treatment were grouped as follows: (a) Operation. (b) Electro-therapy. (c) Massage. (d) Hydro-therapy. (e) Fixation methods. (f) Exercise. (g) Manipulation. (h) Curative manual training in workshops.

The author makes a strong plea that this form of therapy should be more generally introduced into civil hospitals and practice and that facilities should be afforded at medical schools and hospitals for instruction in its science and practice. He quotes statistics to prove its necessity in an industrial country like our own, stating that annually 14,000 accidents with permanent disability occur and that there are in the United States 500,000 persons of working age, who are suffering from vocational handicaps.—*The Military Surgeon*, December, 1919.

SECONDARY WOUND CLOSURE.—Brenizer reports the results obtained in 961 secondary wound closures at Base Hospital No. 6, A. E. F., between April 16, 1918 and December 11, 1918. The majority of these operations were performed from the sixth to the twelfth day after the reception of the wound and the primary excision; that is when the wound has developed not only new tissue formation, but also considerable local resistance, coupled, most likely, with a certain amount of general immunity against the bacteria invading the wound, especially the staphylococci.

After studying the results obtained in the earlier cases, the quantitative bacteriologic examination as prescribed by Carrel was disregarded and all wounds shown culturally not to contain the streptococcus, the gas bacillus and which had had within ten days sufficient antitetanic serum were closed. When these bacteria were present the wounds were treated by the Carrel-Dakin method and those with the gas bacillus also received Bull and Pritchett's gas bacillus antitoxin.

The successful closures were 894 or 93 per cent., the partial successes were 38 or 4 per cent. and the failures 29 or 3 per cent. There was only one death which was due to tetanus in a patient who had received three injections of antitetanic serum, the last less than 10 days before the wound closure. The majority of the patients were moved back to duty within 6 weeks with good functional results.

There were 23 closures over fractures with 18 successes, but these were selected cases with little or no comminution and no small fragments. The results in this type of injury were not very encouraging.

Secondary closure of amputation stumps was successful, but caused additional removal of bone, so was abandoned in favor of traction and spontaneous closure in most cases.

The most difficult wounds to close were those of the hand, the foot and those in which a large circular area of skin had been cut away at the time of the primary excision.

The following technique was used: The surrounding skin was cleaned with ether and painted with iodine and the whole granulating surface was covered with gauze, soaked with iodine. A clear cut incision was made, just outside of the epithelial edge, through the skin, and the skin undermined. The granulating area was then undermined and dissected away en masse, thus removing mechanically the bulk of all bacteria. The granulating tissue was not scraped off, but was dissected off with a layer of the new formed connective tissue down to the fresh, bleeding, underlying structures. The raw area was again painted with iodine and all bleeding carefully stopped. Fascial planes were closed, all necessary repair to tendons, nerves and vessels was done, including curettement of bone, and the skin edges were closed without tension.—*Surgery, Gynecology & Obstetrics*, December, 1919.

**COCYGYDYNIA—FURTHER EXPERIENCE WITH INJECTIONS OF ALCOHOL IN ITS TREATMENT.**—In 1914 Yeomans advocated the treatment of coccygodynia by the injections of alcohol and reported seven cases relieved or cured. He now reports 16 cases clinically cured, 7 relieved and 1 failed. The elapsed time since treatment varies from 3 months to 9 years. Relief for several years justifies the expectation of a permanent cure. Complete relief was obtained in one case by resection of the coccyx after 10 injections had failed to cure. While excision of the coccyx is a simple operation, it should be reserved for those cases in which it is diseased or deformed or after the injection treatment has failed.

**Technique:** The injections are made easily at the office under strict aseptic precautions. The patient assumes the Sims' posture and the region of the coccyx is painted with iodine. An aseptic syringe of 2 cubic centimeters' capacity is filled with 80 per cent. alcohol and armed with a 2-inch needle of fine gauge. With the index finger in the rectum, the point of maximum tenderness is determined by counter-pressure with the thumb on the outside. Usually this is just distal to the tip of the coccyx or slightly lateral to it. Maintaining the finger in the rectum, as a guide and to guard against its puncture, the needle is inserted through the skin in the midline directly to the tender point. When this is reached, the patient may exclaim from exquisite but tolerable pain and 10 to 20 minims are injected slowly. The needle is withdrawn slowly and the iodine on the skin is neutralized with alcohol. The pain from the injected alcohol lasts a few minutes only, but a dull ache may persist for 24 hours. A single injection has cured a few cases but generally one to ten treatments, with an average of three or four, has been necessary. The interval between injections should be from five to seven days and the solution is always deposited at the point found most tender at the time of injection.—*Surgery, Gynecology & Obstetrics*, December, 1919.

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## THE EARLY RECOGNITION OF TUBERCULOSIS IN THE CHILD OF SCHOOL AND PRE-SCHOOL AGE.

BY

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(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

TUBERCULOUS infection may occur at any age. Clinical manifestations of the disease are quite different in early life from those in adult tuberculosis. As a general rule the younger the child, the more acute is the disease. Therefore, infants are subject to very acute forms of the infection, middle childhood to the various sub-acute, chronic and secondary forms of the disease, and the adolescent to the chronic type more closely approaching, in fact often similar to those manifestations that are classical in adult infection.

AVENUES OF ENTRANCE.—Tubercle bacilli may enter the body by means of the respiratory and alimentary tracts, the genito-urinary system, and through the skin. The lung is the most frequent portal of entry in childhood—next in importance is the intestinal tract, and the tonsil is next in frequency. Infection through the skin, mucous membrane of the mouth, nose and genito-urinary tract is rare.

Tuberculous infection may be either of the human or bovine type. It is suggested that when the primary lesion is in the lung, infection is with the human type of the bacillus, due to its peculiar affinity for lung tissue. It is also suggested that the human type may affect the tonsil primarily, the



tracheo-bronchial lymph nodes secondarily, and then the lung substance itself, while the bovine type usually enters by way of the gastro-intestinal or genito-urinary tracts, and that the mediastinal adenopathy in this instance is probably secondary to an extension upward from the mesenteric lymph nodes, and that miliary and meningeal tuberculosis are probably a combined blood and lymph stream infection.

**SYMPTOMATOLOGY.**—The symptomatology of adult tuberculosis is invaluable to the clinician in arriving at a diagnosis, while in children the symptomatology has much less value. This must not be interpreted to mean that a close study of the same should not be made.

It is true that tuberculosis is a definite pathological entity, producing definite clinical symptoms, varying from a slight deviation from the normal to those of gross abnormality. However, these symptoms may be so slight that it is almost impossible to recognize them, and for practical purposes it may be said that tuberculosis can be present in a child without any evident symptomatology.

Some of the following are usually present, namely: Anemia; digestive disturbance, especially difficulty in the digestion of fat; below normal in weight, size and appearance; anorexia; languor; fatigue; change in disposition; fever, sub-normal temperature; flushing; night sweats; perspiration on slight exertion; transient bronchitis; cough (the younger the child the less likely to be present); respiratory dyspnea; tachycardia.

It will also be well to remember that tuberculosis is often found in well nourished and extremely healthy appearing infants and children.

**PHYSICAL SIGNS.**—Interpretation of the physical signs in the chests of infants and young children is extremely difficult, and the physical examination of the chest in a proven case of pulmonary tuberculosis in an infant or young child is very often absolutely negative.

Physical signs found in the chest of infants and children should not be interpreted by those standards usually arrived at from examination of adults with the disease. It must be remembered that all sounds are exaggerated, including the vocal sounds, and the percussion note is practically always hyperresonant. The inability of having a child breathe properly during an examination adds to one's difficulty.

One of the most valuable signs elicited by percussion is

interscapular dullness. This can be elicited posteriorly and occasionally a dullness is found over the upper part of the sternum in front. It is an extension downward of the normal dullness over the cervical spine to include the upper dorsal spine. The presence of interscapular dullness usually means an enlargement of the mediastinal lymphnodes.

As the pulmonary lesions of infants and young children are usually in the right lower lobe, the stethoscopic lung findings are often obtained only with great difficulty and it is only in those cases of apical tuberculosis, or in other words, those children presenting an adult form of the disease in which physical signs by auscultation can be readily elicited.

One of the most important of all physical diagnostic methods for the determination of the presence of enlarged mediastinal lymph nodes is D'Espine's Sign. This consists in the transmission downward below normal limits of the bronchophony heard on auscultation over the cervical vertebrae. When this bronchophony is heard appreciably below the seventh cervical vertebrae, especially when ascertained at or below the third dorsal vertebrae, its pathognomonic value is increased. The enlargement of the mediastinal lymph nodes should be suspected. Spinalgia and tender spine are sometimes associated.

**TUBERCULIN REACTION.**—For practical purposes we will consider only the Von Pirquet, or cutaneous reaction, the intra-cutaneous injection, and the sub-cutaneous injection. The conjunctival application is not recommended for the reason that it often produces serious conjunctivitis. The cutaneous injection being more difficult and uncertain in technique, is very infrequently used.

The Von Pirquet cutaneous test is an application of a few drops of undiluted tuberculin on a portion of the body from which the epidermis has been removed by scarification. The blood vessels of the upper layer should show through, but blood should not be drawn. A convenient instrument is Mulford's tuberculin scarifier. Three raw areas, about one and one-half inches apart, are made on the flexor surface of the forearm. The middle area is used as a control. Tuberculin made by one biological laboratory is placed on the lower area and tuberculin made by a different laboratory is placed on the upper area. The positive reaction shows as a red areola about the site of the inoculation. This reaction usually begins with-

in twenty-four hours, reaching its height during the second day, and during the third and fourth day slowly fades away. The diameter of the areola varies from five to twenty-five millimeters, according to the intensity of the reaction. An areola less than four millimeters in diameter should be considered doubtful, even though the inoculated areas look more red than the control. There is occasionally a general bodily reaction; usually, however, this is not present.

The intra-cutaneous injection and subcutaneous injection should never be used until after the sensitiveness of the patient is first determined by the Von Pirquet test, as very often the reaction is quite severe. The intra-cutaneous test is useful when a doubtful reaction is obtained, or when a negative reaction is obtained, and the clinical and other evidence suggests an almost positive presence of tuberculosis. The intra-cutaneous test is carried out by injecting through a fine needle one-tenth of a milligram of old tuberculin between the skin-layers. Positive reaction is shown by reddening and somewhat painful area at the site of the injection, beginning within twenty-four hours and persisting from three days to a week.

The subcutaneous test gives a general and very often severe reaction. It is carried out by giving a subcutaneous injection of a dose of Koch's old tuberculin, using a too small dose, rather than too large a dose, using from one-one hundredth to one-one thousandth of a milligram. The reaction obtained will transiently increase the inflammation in the structures involved. For this reason it is of value in the differential diagnosis of hip joint disease when etiology is doubtful. This increased inflammation is especially evident in tuberculous cervical adenitis.

The usefulness of the tuberculin reaction is now almost universally accepted. As a general rule, the younger the child, the greater the value of the positive reaction, and likewise the older the child the less value the negative reaction.

The positive reaction is certain evidence of the presence in the body of certain specific anti-bodies produced at some time by the patient being infected with tuberculosis. The anti-bodies are more active immediately following the infection, and for this reason the greater value of the test in infancy and childhood. Mistake must not be made in cases showing clinical evidence of some other lesion which might be non-tuberculous, and taking it for granted that the positive reaction proves



the same to be tuberculous. However, it does increase the possibility of any doubtful lesion being tuberculous.

A weak or doubtful reaction suggests that at some time the child has had a tuberculous lesion, which, however, may be healed, but does not exclude the possibility that the bacilli may still be present and living. A negative reaction does not entirely eliminate the presence of tuberculosis. It is usually absent in miliary and meningeal tuberculosis, during and following measles and some of the other acute infections, and after treatment with tuberculin. And it must be remembered also that if a patient has no resistance to the disease, no, or very little, anti-body is present and, therefore, no reaction is obtained.

Therefore, this will probably explain the absence of a positive reaction in miliary or meningeal tuberculosis, and also in those children who are weak and emaciated, and whose general metabolism is at a low ebb, and at autopsy show the presence of tuberculosis.

**X-RAY EXAMINATION.**—As a general rule the X-Ray findings in intra-thoracic tuberculosis in children are considerably different from those findings usually observed in adult tuberculosis.

As the presence or absence of tracheo-bronchial adenopathy has much to do with the diagnosis of pulmonary tuberculosis in children, it may be well to give a slight anatomical description of the tracheo-bronchial lymph nodes. The two main groups, and those usually concerned in the radioscopic examination are, first, the mediastinal group that include all the tracheal and the mediastinal bronchial glands. All these are situated in the mediastinum between the sternum and spinal column. Second, the hilus or pulmonary group made up of many intrapulmonary peribronchial glands, which follow the bronchi out into the lung substance.

It is difficult to say whether the initial lesion in children occurs in the tracheo-bronchial lymph nodes and that the lung is secondarily infected, or whether the primary lesion is usually in the lung and the lymph nodes are secondarily infected. We are of the opinion that either can be the case, that is, tracheo-bronchial adenopathy may be present without a lung lesion. However, we do not believe that the lung lesion can be present without sooner or later the involvement of the tracheo-bronchial lymph nodes. It is well to accentuate the fact that the

majority of pulmonary lesions found in children have for their location the right lower lobe, this being radically different from adult tuberculosis. Our observations would lead us to believe that more often the primary lesions are in the lung itself, and we are of the opinion that the original focus is usually in a lower lobe. Following this there is an involvement of the glands of the hilus and then the tracheo-bronchial glands, and when the apices are infected, it is usually secondary to these gland lesions.

Fluoroscopy in infants is usually difficult and not particularly satisfactory, while in the child it is of great value in the diagnosis of pathological change in the thorax.

Enlargement of the mediastinal and peribronchial lymph nodes can be detected by use of the fluoroscope. In the direct antero-posterior positions they are difficult to detect for the reason that they are masked by the shadow of the spinal column and contents of the mediastinum and sternum, which prevents the less dense shadows of the glands from being distinguished. Therefore, the mediastinum must be viewed from all angles and by this means enlargement of the mediastinal glands may be detected, which very frequently are not demonstrable on the radiographic plate. The glands are seen as diffuse shadows, sometimes with and often without definite outline, usually occupying a portion of the mediastinum from the seventh rib upward. Hypertrophied or caseous glands are rather diffuse in outline, while calcified or partly calcified glands are more definite in outline. Quite often these shadows extend laterally beyond the mediastinal shadow and then can be demonstrated by a direct dorsal or frontal view; it is these that can also be demonstrated on the radiographic plate. Enlarged hilus glands give an increased density laterally beyond the median shadow and can be seen in the direct antero-posterior positions. The shadows produced by these enlarged glands are often fused with the hilus shadow, and it is difficult to distinguish them. This is especially true of the left side where the heart shadow largely covers this region. Changing the angle of the patient during fluoroscopy, is sometimes helpful in differentiating same, thickening of the pleura or actual lung pathology in this region must also be differentiated. Likewise, encysted fluid is sometimes encountered here.

Fluoroscopy is much more satisfactory in the child than it is in the adult for the reason that a greater penetration due

to the smaller amount of tissue necessary to penetrate makes the screen image much clearer.

It must be remembered the enlargement of the mediastinal lymph nodes is frequently noted during convalescence from some of the acute contagious diseases, especially measles, scarlet fever and probably influenza. Hypertrophy of the thymus gland, tumors of the mediastinum and syphilitic infiltration of the mediastinum are to be differentiated.

Any inhibition or restriction in the movement of the ribs or diaphragm should be noted, likewise failure of any portion of the lung to illuminate properly on deep inspiration. Increased densities produced by pleural thickening should also be observed; outline of the heart, its great vessels, the trachea and the larynx are also inspected.

Where there is lung involvement, the fluoroscopic findings in the child up to twelve years of age are usually definite enough for the skilled observer to diagnose. The older the child the more definite the Roentgen findings in the lung itself, while the less definite the findings in the mediastinum become. The findings in the lung itself are more or less characteristic abnormal changes, the appearance of which depends upon the stage of the disease, location of the lesions, and whether any other non-tuberculous thoracic disease is present, and likewise the consideration of all past diseases affecting the chest.

In children the bronchial tree is much more invisible beyond the hilus area than in the adult. In other words the younger the child the less one can demonstrate the normal bronchial tree by fluoroscopy and the radiographic plate, and usually when the bronchial tree is visible to periphery of any portion of the lung, one should be suspicious of the presence of pathology.

In adults the tuberculous lesion is almost always apical. In children apical tuberculosis is rarely encountered, and when present is usually secondary to basal lesion.

It is, of course, necessary to differentiate the pathology found from other thoracic diseases such as pneumonia of any type, post-pneumonic congestion, bronchiectasis, foreign bodies, syphilis and in fact any interstitial inflammation.

In pulmonary tuberculosis markings of peribronchial infiltration are noted running out from the hilus areas, or lung root, toward the periphery of that portion of the lung infected,



or from the periphery toward the hilus area. The more hazy, blurry, or smoky these markings appear, the more active the lesion, and, therefore, the more cleancut and the more linear the markings, the less active the lesion.

The presence of calcified glands suggests that the lesion is of considerable duration, or is a reinfection. As a general rule the more calcified glands noted, the better the prognosis. The changes from the hilus to the periphery are variable in appearance, and the whole chest picture is rarely homogeneous except when miliary tuberculosis is present. The latter appears as mottling or granulation of the entire lung shadow.

In older children advanced tuberculosis is demonstrated by the presence of this peribronchial infiltration associated with cavitation, which is demonstrated as sharply defined circumscribed shadows, which are devoid of lung markings. Cavitation in young children is very rare.

Roentgen findings of healed tuberculosis depend upon the original progress of the disease. The usual findings are: Linear markings are denser, slightly broader and more cleancut in appearance. There is very little studding along the bronchial branches. The peripheral linear markings are absent, or are broken up and cannot be traced continuously. The hilus areas are more dense and cleancut. Calcified areas are noted at lung roots and smaller calcified glands are observed throughout the lung shadow. The entire picture is changed from one of the varied appearance to a more homogeneous one. Parietal inter-lobar and diaphragmatic, pleuritic and cardiac tractions are denser and more cleancut.

Stereoscopic plates are undoubtedly far superior to the single plate. However, in young children it is impossible to get them for the reason that the child changes its position before the second plate can be placed in position and the tube shifted. It is always well to take both an intero-posterior and postero-anterior view. Very often a lateral view gives additional and helpful data.

Stereoscopic plates give one more accurate information as to the actual location of the lesion and often will be the determining factor in differentiating the healed from the active process. The findings are essentially those found during fluoroscopy, with the exception, of course, of the information gained from the viewing of the moving viscera. Lung markings do, however, show more plainly. In the normal chest

the bronchial tree can be traced a little further out from the hilus area than that seen on the screen.

SUMMARY.—The opinions expressed are from the observations resulting from the physical and X-Ray examination of 700 school children at the X-Ray Laboratory, Department of Hygiene, Pittsburgh Public Schools:

1st—The primary pulmonary lesion of tuberculosis in children is usually found in the right lower lobe.

2nd—Enlargement of the mediastinal and peribronchial lymph glands either follows or precedes every pulmonary lesion of tuberculosis.

3rd—Pathology, symptomatology, physical diagnosis and X-Ray findings are distinctly different from those found in adult tuberculosis.

4th—Fluoroscopy is perhaps the greatest aid in the diagnosis of intrathoracic tuberculosis in children.

5th—Intrathoracic tuberculosis is often present and after careful examination the physical signs are negative.

6th—Tuberculosis is the most important chronic disease in infancy and childhood.

7th—In the diagnosis of thoracic tuberculosis in infants and children, the following procedures are the most valuable:

- a. History of exposure.
- b. Fluoroscopy.
- c. Radiography.
- d. Symptomatology.
- e. Tuberculin reaction.
- f. D'Espine's sign.
- g. Interscapular dullness.
- h. Changes in the breath sounds over lung areas.
- i. Microscopy of sputum and animal inoculation.

#### REFERENCES

- Barjon, F.—Radio-Diagnosis of Pleuro-Pulmonary Affections.  
 Bissell, F. S.—Roentgen Symptomatology of Pulmonary Tuberculosis.  
 Combe—Clinical Forms of Tuberculosis in Children.  
 Cooke, W. E.—The X-Rays in Pulmonary Tuberculosis.  
 Dunham, K.—Stereo-Roentgenography, Pulmonary Tuberculosis.  
 Dunham, K.—Roentgenographic Diagnosis of Pulmonary Tuberculosis.  
 Dunham, K.—The Relation of the Pathology of Pulmonary Tuberculosis to the Roentgen Findings.  
 Dunn, C. H.—The Hygienic and Medical Treatment of Children.  
 Fishberg, M.—Pulmonary Tuberculosis.  
 Ghon, A.—The Primary Lung Focus of Tuberculosis in Children.  
 Hirsch, I. S.—Summary of The Roentgen Diagnosis of Pulmonary Tuberculosis.

Holmes & Ruggles—Roentgen Interpretation.  
 Kerley, C. G.—Practice of Pediatrics.  
 Koch, H.—Tuberculosis in Infancy.  
 Knox—Radiography and Radiotherapeutics.  
 Lord—Diseases of Bronchi, Lungs and Pleura.  
 Morse, J. L.—D'Espine's Sign in Childhood.  
 Norris & Landis—Diseases of the Chest.  
 U. S. Army—X-ray Manual.

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## A HISTOLOGIC CONSIDERATION OF INTERMEDIARY TUMORS.

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THE object of this paper is a brief discussion of the present day conception of intermediary tumors. By "intermediary tumors" is meant those tissue proliferations which are not marked or disorderly enough to classify with the host of benign and malignant tumors, and are too marked to classify with productive inflammation and repair. Since these growths lie between true tumors on one hand and inflammation and repair on the other, it would not be amiss to compare tumor growth and inflammation with a view of revealing just what intermediary tumors are or are not.

Inflammation, the reaction to injury, may be divided into the acute and chronic type. The first presents changes most marked in the blood; while in the latter the fixed tissue changes are the salient features. Coincident with acute inflammation there is a destruction of tissue which nature sooner or later repairs or attempts to repair. This regeneration is not to be confused with inflammation proper, though inflammation and regeneration may both be happening in a tissue at the same time. The phenomena of inflammation are familiar to everyone. Besides the blood cells which pass from the vessels into the surrounding tissue, there appear the so-called wandering cells, which though taking no part in the formation of fixed tissue, are believed to be derived from the fixed tissues.

When tissue is destroyed there is a repair of the part. The cells which proliferate may be the special cells of the area



destroyed; but more often it is connective tissue which fills the gap. This tissue of course does not functionate and may even be injurious. Usually, however, it observes an adaptation to the function of the organ or part destroyed. Inflammatory hyperplasias become injurious when they continue to increase after the irritation has ceased—a condition which prevails when the cells seem to have gained a momentum and continue reproduction without any further stimulus.

Inflammation and repair are distinct as to cause, aim and cells involved. One is due to injury, the other to destruction resulting from the reaction to injury; one aims to remove the cause, the other to repair the damage done; one involves blood and the wandering cells of the body and the other involves fixed tissue cells. Just as connective tissue forms a stroma for parenchymatous cells, so the fibrin resulting from the extrusion of plasma in inflammation, acts as a stroma for the fibroblasts in the process of repair.

A process beginning in a simple inflammation may assume the properties of a neoplasm. Should a neoplasm occur in the course of an inflammatory hyperplasia, then something new is added; which fact is difficult to realize when the change is gradual. With every increase in quantity there is a change of quality, so the gradual and sometime sudden variation in morphology and behavior of the cells may be expected; but the appearance of a tumor in inflammatory hyperplasia is usually quite marked and as a rule different in form from the pre-existing hyperplasia of the same tissue.

The morphology of true tumors is unlike that of inflammatory overgrowth and physiological repair. A productive inflammation is as a rule a diffuse process involving an organ or tissue and grades off into the normal. Neoplasms usually are circumscribed because of their origin from an isolated group of cells. Productive inflammation involves all the elements of a tissue; while tumor processes generally adhere to a single cell type. Inflammatory hyperplasia is confined by narrow limits; a tumor knows no bounds. The cells of a tumor show anaplasia, loss of specific form, multiform nuclei and atypical mitoses; which features are absent or at least less marked in productive inflammation. It must be remembered, however, that the shape of the cells can not be taken as a criterion by which to judge the nature of a tumor.

More important is the arrangement of the cells, their relationship to each other and to the stroma.

Tumors and inflammation spread by the same routes; lymphatics, blood stream and by continuity or contiguity of structure. An essential difference is in their formation of metastases. Infectious growths are reproduced by the parasite or causative agent itself being carried by the blood or lymph to incite a new tissue proliferation at the metastatic site; while tumors metastasize by the transplantation of a part of the parent growth.

As previously stated, nearly all that can be said of true tumors and inflammation can be said of intermediary tumors. They may be inconvenient, disfiguring or dangerous from their size or location; they may be destructive to the tissues in which they are situated; and they may present peripheral fibrous changes, round cell infiltration and all varieties of degeneration and secondary deposits found in destroyed tissues.

A realization of what is meant by intermediary tumors will follow the mentioning of a classical example, as; Hodgkin's disease. And immediately will be recalled other intermediary grades of hyperplasia which at times are encountered with nearly every tissue cell in the body.

The most interesting types of these hyperplasias are found in the lymphoid tissues. Especially may this be said of Hodgkin's disease. Here is present a diffuse cellular hyperplasia due to some, as yet unknown, stimulus. In the glands are found varying proportions of proliferating endothelial cells, the rapid growth of which may be assumed by the appearance within them of occasional mitotic figures. Not infrequently these endothelial cells fuse to form giant cells. The growth of these cells is limited to lymphoid tissue; but apparently unlimited within it. Signs of acute inflammation are lacking, though plasma cells and eosinophiles are generally found. Fibrosis of the affected nodes is the usual final change. The marked enlargement of the affected glands, the appearance of the same histologic picture in other lymph glands of the body, and the marked proliferation of a specific type of cell, tend to a resemblance of a neoplasm.

Other chronic hyperplasias of the lymph glands, of a questionably malignant nature are sometimes found. In lymphatic leukemia all the lymph nodes of the body may be more or less enlarged. With this condition is an enlargement

of the spleen. Such a process shows an increase of all the tissue elements; but unlike Hodgkin's disease, no fibrous changes follow. The excessive growth of lymphoid cells is limited to the lymphoid tissue proper and does not infiltrate. It is not the rule for fibrosis to occur in these glands, though they may present a thickened capsule. Here too is lacking evidence of acute inflammation.

Chronic lymphadenitis may resemble certain tumors both morphologically and clinically; the cells showing structural changes which resemble feeble neoplastic growth. Such conditions do not have the definite signs of Hodgkin's disease, syphilis or tuberculosis; but resemble the so-called lymphomas, from which they are difficult to distinguish. Lymphosarcoma stands between sarcoma and the so-called infectious granulomas. The latter may present a proliferation of the reticulum cells, producing the appearance of a large cell lymphosarcoma, or an increase of endothelial cells simulating endothelioma.

Though they do not proliferate in other tissues or form metastases, the bone marrow tumors, myelomas, fall into the intermediary class by their extreme reproduction of cells. The important cells of the bone marrow are the osteoblasts and osteoclasts which are directly concerned in bone formation, and the erythroblasts, megalocytes, myeloblasts and lymphoblasts which are the mother cells of the red blood corpuscles and leucocytes. In some instances the osteogenic elements are hyperblastic; in others the cytoplasmic; in still others both elements are involved. In spite of the excessive growth of the myeloblasts or lymphoblasts, the cells remain in the marrow and are not as a rule found in the circulating blood. Occasionally, however, lymphoblastic and myeloblastic tissue may be found in other parts of the body, giving rise to a leukemic picture.

On the other hand in leukemia there is an abundant discharge into the circulating blood of the hyperblastic elements, and further evidence of marrow activity is seen in the great numbers of eosinophiles, basophiles and nucleated red corpuscles in the peripheral circulation. The leukoblasts affect the lymph glands and spleen, where in each instance they are found abundantly deposited. It is generally conceded that the lymph gland and splenic enlargement is secondary.

Another intermediary tumor of the bone marrow is chloroma in which is found a lymphoid overgrowth with a



marked reticulum containing medium-sized round cells. Some contend that chloromas are periosteal or bone growths; but spindle cells, giant cells and the tendency to bone formation, found in periosteal tumors, is lacking. Associated with this condition is a type of leukemia characterized by a prevalence of myeloblasts.

Enlargements of the spleen, irrespective of the cause, present many tumor features. The change in Hodgkin's disease has been touched upon, as has the infiltration in leukemia. The splenomegaly of Gaucher type reveals an overgrowth of endothelium. Large endothelial cells are found in the splenic pulp and the occasional mitotic figure within these cells suggests their increased power of growth. Changes of a similar nature in the lymph glands and bone marrow are associated with this type of splenomegaly.

The thyroid gland is of interest in connection with the type of tumors under discussion. It is not uncommon to find in the normal adult thyroid, localized patches which resemble the embryonic state. These areas show within the stroma as collections of small vesicles lined with cuboidal epithelium, suggesting an adenomatous state, and may be unjustly considered adenomatous because the vesicles may be mistaken for a new formation. The approach to the picture of a true tumor of the thyroid is encountered when the hyperplasia of the epithelium is such that the cells are heaped up and protrude into the lumen when new glands are found, when mitotic figures are present and perhaps giant cells. The fact that the basement membrane is very delicate in the thyroid tends to the mobility of the epithelium and the migration of these cells in extreme hyperplasia, into the stroma. It is of interest too, to note that various physiological states may stimulate cellular hyperplasia in the thyroid which may equal that of some malignant tumors; but which retrogress.

The tissue changes of chronic mastitis quite often resemble malignancy. In this breast condition are revealed foci of epithelial overgrowth and marked increase of connective tissue with an infiltration of plasma cells and lymphocytes. This condition may resemble adenofibroma without encapsulation, and may indeed be difficult to differentiate. So in prostatic hypertrophy a borderline picture of neoplastic growth may be found, especially when there are present new gland formations with the heaped-up epithelium projecting into the

acini. The infiltration of round cells; the multiplication of small aveoli and scanty stroma of some simple hypertrophies may closely resemble the picture of adenoma.

In some cases of hyperplastic endometritis, malignant-like tissue changes may be found. The uterine mucosa may be greatly thickened, very vascular, cystic and covered with papillary or polypoid projections. There may be present an excessive overgrowth of large, irregular, compact or dilated glands. The cells may be enlarged, their nuclei hypertrophic and present mitotic figures, and the layers of cells be multiple. Every gradation may be found from the normal to malignant adenoma. The interstitial tissue may present large flat decidua-like cells, lymphocytic and plasma cell infiltration.

Peculiar cellular proliferations are met with in tuberculosis and syphilis. While the pathology of tuberculosis is usually a hyperplasia, with secondary destruction and caseation, it is not impossible to find hyperplasia without caseation. In such instances the endothelial cells are numerous, the fibrous tissue greatly increased and the lymphocytes comparatively few. Giant cells may or may not be present, and the hyperplasia difficult to distinguish from sarcoma. The same may be said of syphilis, which stimulates an overgrowth of round and spindle cells resembling sarcoma, though the tendency of luetic lesions is toward necrosis and cicatrization. Some have observed that sarcomas have their origin in syphilitic tissue changes; but the fact has not been definitely proven. It cannot be denied that certain syphilitic lesions appear much like, even if they do not develop, sarcomas.

Certain tropical diseases give rise to cellular hyperplasias which, generally speaking, present a histology similar to that of syphilis and tuberculosis, and analogous to infective granulomas. Witness, too, the proliferation of cells in the lymphoid tissue of the intestine in typhoid, as a vague example of rapid growth without true tumor formation.

Productive inflammatory lesions of a typical nature and granulation overgrowths have much in common with sarcomas. In wound healing, particularly those of the periosteum and bone, the histologic picture shows very active cellular proliferation, with giant cells, connective tissue cells and regenerating capillaries. That such conditions have given rise to sarcomas cannot be doubted.

All fixed tissue cells have the power to form tumors.

Because of some stimulus, known or unknown, the cells reproduce rapidly; but the daughter cells do not functionate and so lose their role in the organism, serve no useful purpose and are harmful more often than not. Hypertrophy, hyperplasia and migration are the fundamental protective activities of the body and represent hyperactivity, reproduction and change of environment respectively. When the migration stage is reached the cells are entirely parasitic, and the field of malignancy is entered. Intermediary tumors present all these changes to a degree. They cannot justly be called pre-cancerous; but by their further study—etiologically, histologically and chemically—they may prove to be the “missing link” in the chain of sequences between irritation and neoplasms.

## REFERENCES.

- Adami, J. G., *Principles of Pathology*, ed 2, Philadelphia, 1910, Lea and Febiger, i.
- Adami, J. G., and Nichols, A. G., *Principles of Pathology*, Philadelphia, 1909, Lea and Febiger, ii.
- Barker, L. F., *Monographic Medicine*, New York, 1916, D. Appleton and Co., ii.
- Ewing, J., *Neoplastic Diseases*, Philadelphia, 1919, W. B. Saunders Co.
- Hertzler, A. E., *Treatise on Tumors*, Philadelphia, 1912, Lea and Febiger.
- Mallory, F. B., *Principles of Pathologic Histology*, Philadelphia, 1914, W. B. Saunders Co.
- MacCallum, W. G., *Text-Book of Pathology*, Philadelphia, 1916, W. B. Saunders Co.
- MacCarty, W. C., *Amer. Jour. Med. Sc.*, 1919, clvii, 657.
- Saint, C. F. M., *Brit., Med. Jour.*, April 18, 1914, 848.
- Stengel, A. and Fox, Herbert, *Text-Book of Pathology*, ed 6, Philadelphia, 1915, W. B. Saunders Co.
- Wells, H. G., *Chemical Pathology*, ed 3, Philadelphia, 1918, W. B. Saunders Co.



**PERSONAL EXPERIENCE WITH A NEW ANTISEPTIC.**

BY

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and Assistant Surgeon to Hahnemann Hospital.(Read before the Homœopathic Medical Society of the State of Pennsylvania,  
September 17, 1919.)

FROM the time of asepsis and antiseptis, every antiseptic placed on the market, has been used by the surgeon and general practitioner with varied results.

Carbolic acid, bichlorid of mercury, flavine, bromin, iodine, Carrel-Dakin solution, di-chloramin-T, all have their advantages and disadvantages; the idiosyncrasies of the patient having more or less bearing on the results.

To-day, I want to add to the already almost innumerable list, still another antiseptic, "Chlorlyptus," which I have been using for one and one-half years with almost incredible success.

Anticipating a few questions relative to the length of time this has been in use, and of what it is composed, I will state in answer to the first, just one and one-half years, the time I have been using it, and to the second and more important, Chlorlyptus antiseptic is made by subjecting a specially prepared oil of eucalyptus to the action of anhydrous chlorin gas, until the oil has absorbed 30 per cent. chlorin gas by weight. The resultant is a monochlorid of eucalyptus oil, the principal constituent being  $C_{10}H_{16}OCl_2$  (equaling chlorine) 31 1/10 per cent., with acid reaction.

Chlorlyptus differs from other chlorinated antiseptics, (i. e. the hypochlorite and chloramine types) inasmuch as the contained chlorin is not available as free chlorin, and therefore is not subject, in any of its admixtures, to deterioration, and by reason of this, is safe to use at all times. It is also non-toxic and non-irritating.

It has a phenol coefficient of 2.6 as determined by physiological chemistry.

In clinical use, it is diluted with paraffin oil in ratio of 1 to 5, thus lowering the bacteriocidal power to less than one-half that of carbolic acid as determined by method of the United States Public Health Service.

By reason of its oily nature, chlorlyptus is not a coagulant, and is, therefore, not strictly comparable as to bactericidal power with the tests used in determining bactericidal power of non-oily antiseptics.

In water admixture—1 dram to gallon, ratio about 1 to 1,000. Chlorlyptus has a bactericidal power sufficient to kill staphylococcus aureus and other purulent germs.

Just here it might be well to read you a report on chlorlyptus experiments on skin and hand disinfection, as published by one of our Philadelphia Hospitals.

*Experiment No. 1.*

Finger (unwashed and undisinfected) dipped in sterile bouillon (45 c. c.) for five minutes. One c. c. of litmus lactose agar by mixing it with 10 c. c. of liquified agar and cooling in Petri dish.

Result: Subject A. 1800 colonies  
                   “ B. 18000 “  
                   “ C. Innumerable colonies.

*Experiment No. 2.*

Finger disinfected with pure chlorlyptus for five minutes (without previous washing) then dipped in bouillon for five minutes and 1 c. c. of the bouillon plated at once.

Result: Subject A. Sterile  
                   “ B. “  
                   “ C. “

*Experiment No. 3.*

Finger washed 15 minutes in surgical procedure and rinsed in sterile water. Dipped in bouillon five minutes and the inoculated bouillon plated immediately.

Result: Subject A. 1890 colonies  
                   “ B. 2070 “  
                   “ C. 135 “

*Experiment No. 4.*

Finger washed for 15 minutes in surgical procedure and rinsed in pure chlorlyptus. Dipped in bouillon five minutes and the bouillon plated as before.

Result: Subject A. Sterile  
                   “ B. “  
                   “ C. “

Before going into detail regarding the efficacy of chlorlyptus, I wish it understood that it is not to take the place of vaccine, both stock vaccine and the autogenous vaccine being

used by me and others with the most gratifying results; but I am calling your attention to this wonderful antiseptic, (as I have reason to consider it) to be used in the cleansing of infected wounds, the elimination of pus and encouragement of rapid healing by healthy granulation. I have used it exclusively for one and one-half years in empyema after rib resection, appendicitis and other acute abdominal conditions with free pus—in cases of furuncles, carbuncles, infected fingers, ischio-rectal abscesses, fistula, gun shot wounds, osteomyelitis and in emergency cases from industrial plants, made more virulent by dirt and filth; also where tissues were badly macerated requiring amputation. In all these cases we have found that the best treatment is to use the watery solution for cleansing purposes, and where a drain is necessary, we saturate sterile gauze with a 5 per cent. oily solution.

It is very efficacious in the treatment of burns: 1 part chlorlyptus to 14 parts unguentum petrolatum.

In the treatment of empyema thoracis after rib resection and the insertion of drainage tubes, at the first dressing, the cavity is irrigated with the watery solution in the strength of 1 drachm to the gallon, using large quantities until the fluid runs clear. In a few exceptional cases of large quantities of pus, after the irrigation with the watery solution, about 2 ounces of the 5 per cent. oily solution are injected into the cavity and allowed to remain. All abscess cavities and in every case where it is necessary to use drainage, I make use of a pack of sterile gauze saturated with the oily solution.

It is non-irritating to both the patient and the physician, and some surgeons claim that after cleansing their hands preparatory to operating, immersing them in the stock solution of chlorlyptus 30 per cent., eliminates the necessity of rubber gloves.

I have recommended chlorlyptus to my colleagues when they have spoken to me of the discouraging results of other antiseptics, and their subsequent reports to me gave testimony to the most brilliant reaction.

Let me quote from observations made in our own Hahnemann Hospital by one of our residents:

Owing to the impracticable methods to carry out the Carrel-Dakin treatment of wounds in the hospital, we welcomed any antiseptic which offered as good if not better results, with a simpler method of application. Chlorlyptus, in its different percentages, for different usages, has given us such wonderful results that to endorse



it is only to recommend it because of our experiences. Because of the irritation caused by Carrel-Dakin in the treatment and the taste of chlorin, in cases of empyema thoracis so annoying to the patient, we decided to try chlorlyptus. With this, the patient experienced no untoward effect such as a bad taste or any dermatitis around the wound.

In carbuncles, after making a crucial incision, and removing all the sloughing tissues, the cavity is swabbed with a 1 per cent solution and a piece of gauze saturated in the 5 per cent oily solution is placed in the wound. In a few days all sloughs are absent, and nothing but a red, healthy surface remains. By continuous use of chlorlyptus the granulations gradually fill up to the surface, and little contraction of the skin remains as under the more radical treatment.

In our receiving ward all wounds, many of them being necessarily dirty, are cleansed with the watery solution, and the 5 per cent oily solution is poured over the wound, after which it is sutured in the usual manner. Even in the dirtiest scalp wounds found in drunks, the results are surprising, and infection almost nil. We employ this antiseptic in coryza by a spray of the watery solution, in the uterus following dilatation and curettage, for septic cases as an irrigant, also in urethritis and as a douche for leucorrhœa.

In conclusion I will state that, with such encouraging reports from others, besides my own successes with chlorlyptus, and with the added attraction of being able to prepare and keep it for any length of time without losing its strength or efficiency, I feel I am justified in continuing to extol its virtues and to recommend for all infected wounds, this latest ideal antiseptic, "chlorlyptus."

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### SOME EXPERIENCES WITH HOMŒOPATHIC REMEDIES IN SURGICAL CASES.

BY

FREDERIC MCN. E. HOWELL, M.D., READING, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, September 17, 1919.)

THIS is not a technical paper, nor is it intended to be a discussion of the various remedies applicable to surgical conditions, but rather it is an attempt to do homage to homœopathy by a mere statement of facts—a simple testimony to the efficiency of the homœopathic remedy in situations where, I am perfectly satisfied, I would have lost my patient without its aid.

CASE No. 1.—Mrs. E., aged 46, married, mother of two children, younger aged 18. Mrs. E. apparently healthy, robust, accustomed to doing her own housework; medium height and of very dark complexion; had had no serious ill-

ness until three months prior to the time I saw her, at which time she had an attack of pain in the right side which was relieved by hot applications, but returned the next day, and bothered her a great deal during the following week or so, when she was compelled to go to bed. She called in an old school physician who attended her for several weeks. Her condition grew steadily worse. She had a temperature of 100 degrees, chills and sweats, anorexia and nausea, and became greatly emaciated. A surgeon was called in consultation and a diagnosis of abscess or Addison's disease was made, the latter, no doubt, because of her dark skin and the presence of two black spots on her upper lip, which she said had been there as long as she could remember. She was treated with opiates and antiphlogistine, and finally given up. The day I was called in, her physician had left with the statement that her death could be momentarily expected. On examination, I found a tumor in the right loin, hard and smooth, and extremely sensitive to pressure. The patient was completely prostrated, with weak and irregular pulse. The patient constantly asked for water, which was taken only in sips. Legs were cold, and patient listless and exhausted. She had been having the worst pains in the morning, and for the past several days, the pain had been so severe at that time that she needed a hypo for relief. Because of a periodic pain, right-sided, water in small quantities, I prescribed Arsenic 3x every half hour, and said I would call in the morning, when the pain was at its height. Calling the next morning I found the patient showing improvement. She had slept six hours, had no pain until just before my arrival, and a hot application had already relieved her. The tumor was still the same and very sensitive. She again slept all that night, and the next day asked for food. The pain was now of a dull character, and easily borne, the tumor seemed softer but still sensitive. In four days, it was barely possible to distinguish it, pain entirely gone, and in two more days, both had entirely disappeared. The patient went on to rapid and complete recovery, being downstairs and at her housework in three weeks. There was never a return of these symptoms, nor any sign of the evacuation of an abscess. The urine at no time showed pus. Patient remained in perfect health for a year, when I was called to attend her for cardiac asthma, following her housecleaning; and twice afterward, at intervals of several months, for the same condition. Arsenic

relieved promptly on each occasion. I saw little of her after that but she had practically no symptoms except slight asthmatic attacks, until her death five years after the first illness, from dilatation of the heart.

CASE NO. 2.—Mrs. D., aged 51. Mother of four children, had been treated by an old school physician for metrorrhagia and prolapsus uteri. She was sent to the hospital by a chiropractor, whom she had called in to treat her. He realized, as he said, “that it wasn’t anything for him to monkey with.” Examination revealed a large vaginal tumor filling the pelvis with the cervix posterior. It was impossible to determine whether the tumor was attached to the cervix or incorporated in the body of the uterus. Excision of a plug, however, proved it to be a fibroid. The patient was extremely weak from the loss of blood, and begged to be treated for a day or two for the weakness, saying she would do anything I wished if she could just get a little stronger, as she tearfully said: “I know I’ll die if I have to go through it now.” She was pallid, weak, and her pulse rapid, weak, but regular. Legs swollen to the hips to twice their normal size. She had several thrombotic piles which gave her constant pain. Rest in bed, with legs elevated, astringent douches, ipecac, calc. carb. for the metrorrhagia and bry, apocy. hypo of dig. for the edema. The metrorrhagia was controlled somewhat, but though she felt slightly stronger, no perceptible change could be noted in the legs. The patient wept continually, and one had but to look at her to start the flow of tears in increased volume. She was gentle and submissive, but “just could not stop” the tears. This symptom, though she was a pronounced brunette, with the venous stasis, suggested pulsatilla, a drug I never had a satisfactory result with before; but I gave it in the “I-X,” every hour. The tears were controlled in a few hours. I discontinued all remedies except puls. In twenty-four hours a perceptible change was noticeable in both legs. At the end of a week the legs were normal, hemorrhoids had disappeared and metrorrhagia, tears and piles and piles of tears greatly decreased in amount. In two weeks the patient was eating three good meals a day, sitting up in bed, while all bleeding had stopped. I then suggested that the time had come for an operation, when the patient exhibited anything but a puls. disposition, saying most emphatically, “NO operation. If medicine can do this, it



can fix me all right." She could not be induced to change her mind and in a week's time went home, where she was soon at her wash tubs. I examined her six months later, and found the tumor apparently the same but no engorgement of the tissues. She had not been troubled by it in any way, except a feeling of pain in the rectum, and constipation at times. Several times after this I gave her *pulsatilla* for a slight bloody discharge and swelling of the ankles. The medicine relieved these symptoms. I heard nothing of her for some time after this, but learned that she had done fairly well for about two years, after which severe rectal trouble developed. She tried various treatments, still refusing operation, and died at the end of another year, of cancer of the rectum.

CASE NO. 3.—Miss F., aged twenty-eight, sent to one of the Wernersville Sanitariums by a Philadelphia physician. I was asked to treat her for rheumatism and gave her *phyllogens*. By the end of two weeks her joint pains were improved, though she was very weak; heart action irregular, and temperature, which had been showing a slight daily rise, was normal. After a few days, patient had a slight bloody vaginal discharge, with a foul odor, and abdominal distress. I sent her to the hospital with the intention of doing a curettage. Soon after her arrival there, her abdominal pain became severe, her temperature shot up to 104 degrees. She complained of oppression over the heart and a distinct murmur could be heard over the mitral region. She was given hot bichloride douches and enteroclysis. The cervix was enlarged and soggy, and pain centered over the appendix and right ovary, both of which were extremely sensitive to pressure. The temperature zigzagged between 97 degrees and 103 degrees. I was asked to consult with a Philadelphia surgeon before operating. By the time he arrived the patient was showing signs of peritonitis; frequent vomiting, pinched face and some distension. His remark, after looking her over was: "She is septic all through. You can do a coeliotomy if you want to satisfy yourself, but *I* wouldn't touch her; she'll die on the table." He further expressed himself satisfied that there was nothing more to be done for her, and left the matter for any further treatment to me without any suggestion.

I prescribed *crotolus* 6x every half hour for six doses, then every two hours. Improvement was evident in a few hours. The patient went on to recovery without any sign to

indicate whether or not we had had an ovarian abscess. The heart gradually improved and in four or five weeks patient was discharged and sent to Atlantic City. This was two years ago. I have been told by one of our prominent medical men here who has treated her since, that she was in good condition and had no evidence of any former symptoms except a heart condition which readily responded to treatment.

CASE No. 4.—Mrs. L., aged 68, had an attack which was diagnosed as gall stones by an old school physician, who took her to Philadelphia for operation. An X-ray by a prominent Philadelphia Roentgenologist revealed no gall stones but a “tumor of the pancreas.” This patient returned to her home without undergoing operation, and was confined to bed for eleven weeks before I saw her. She had then been given up, the physician stating that she had cancer. She was emaciated (had been very stout, weighing 190 pounds). She was deeply jaundiced from head to foot, which condition had existed from the first week of her illness. Constant nausea, vomiting and occasional diarrhoeic stools with pain in the abdomen, was the train of symptoms exhibited when I was called in to do something, if I could, to relieve her distress, “though, of course, they knew she couldn’t live.”

I prescribed colocynth, with not a great deal of expectation, and making no promises, nor giving encouragement. The patient recovered, to the surprise of all, under this treatment, no other remedy being given except chin. ars. and nux, several weeks later. Patient was in fine condition after her recovery, going about in perfect health for five years, and regaining her former weight, good color and vitality.

Several months ago she called to see me for abdominal distress. A glance told the story. While she still looked well, a recent and greater gain in weight coupled with an appearance of scrawniness, and loss of flesh around the neck and chest, made a typical picture of abdominal tumor. Inspection soon demonstrated the presence of fluid. She finally followed my advice to have it removed while she was still in good condition, and three weeks ago the cyst was evacuated and six gallons of fluid removed. She is now up and about, showing evidence of returning to an active life at seventy-four years of age.

I have been in a way pessimistic regarding death-bed reactions as a result of medication, but after retrospective medi-

tation I have decided to be more optimistic in this line and believe it my duty, after bathing in the glory of these remarkable recoveries to testify to the efficiency of the indicated remedy in such cases.

One reason for the selection of these particular cases is the fact that others beside myself, quite capable of judging, reached the same conclusion in regard to their status. In three instances those who had had their turn first with other remedies announced their failures. I also wish to call attention to the fact that where a definite surgical lesion was proven to exist, it was also proven that surgery at a propitious time would have made the cure complete; and that a cure cannot be claimed until all such conditions are removed.

The remedies of precision are few. Stimulants and other remedies used for the short boost, remedies with a "kick" in them are satisfactory to the minds of many for a brief, forcible reaction; but for continued action they are often as uncertain as the flavor of an uncut canteloupe. When all others fail—use HOMŒOPATHY! "Best in the long run!"

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## ECTOPIC PREGNANCY.

BY

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(Read before the Homœopathic Medical Society of Germantown, Nov. 15, 1919.)

IN casting about for a topic which would interest the general practitioner as well as the specialist, I concluded to write upon the subject of ectopic pregnancy. I decided upon this because I find some of the profession are not awake to the fact that this condition is not rare and that if the mind is kept open and alert many women will be saved weeks of treatment for pelvic pain and invalidism, to say nothing of the danger to unrecognized cases. Keeping in mind, then, the possibility of an ectopic pregnancy, and consultation with a specialist when in doubt, will prevent untold trouble and subsequent annoyance and chagrin to the attending physician.

In discussing any surgical subject before a mixed body of medical men, one is confronted with two kinds of phy-



sicians. There are certain men who are always on the lookout for surgical cases, making every endeavor to get them to the operating table early while there is a good chance for complete recovery; and another class who feel somewhat like the native who lived so far from civilization that it was impossible to secure the services of a doctor. When asked by the visitor how they managed to get along without a physician, he replied, "Wa-al, ye see, most of us have to die a natural death."

I am not here to tell you it is always easy or possible to make a positive diagnosis of ectopic pregnancy. Some cases are so easy that it is practically impossible to make any other diagnosis, while others will defy the skill of the expert. I heard a specialist assert that there is no excuse for failure to recognize this condition, and I have operated and demonstrated that the condition was present in a patient whom this doctor had examined, treated, and failed to recognize the pathology present. I respect the skill of the doctor mentioned as a diagnostician, for he is very skillful, but I cannot agree with his theory as to the ease with which a positive diagnosis can be made in all cases.

Let us all remember, therefore, that no one of us is infallible and to be charitable to all when mistakes are made. As diseases progress conditions change, and it may be that the man (who thinks he has made a diagnosis where others failed) was called to the case at a favorable time, and that had he been called when the first doctor saw the case, he would have been just as much at sea.

In my opinion no one can be sure of his diagnosis when the history, symptoms and physical signs are not all present. I believe that all operators will agree that there are times when we are morally certain that we are dealing with an ectopic pregnancy, but because of the absence of one of these three factors, we cannot say positively that this condition obtains.

However, we need never make the mistake of operating upon a patient unnecessarily because we can determine if the case is surgical even when there is some doubt as to the exact nature of the pathology present.

With this preliminary discussion, let us take up the history, symptoms, physical signs, diagnosis and treatment of ectopic pregnancy.

The previous history is fairly important and consists in the fact that the patient has been sterile, for some unknown reason, for a number of years. This is, however, not constant.

The present history is more interesting and in brief I would say that the patient has considered herself pregnant for about two months when she is seized with a severe pain in one side of the pelvis, usually of a crampy nature. This may be attended with fainting and collapse; in other words, the patient is in a condition of shock with feeble and rapid pulse and subnormal temperature. If the bleeding has been very profuse the abdomen will be distended. This represents the acute type and may prove fatal if prompt surgical measures are not initiated. Physical signs may or may not be present. Liquid blood does not form a palpable mass.

The most common form of ectopic pregnancy begins as above with the symptoms of pregnancy followed in the usual time by sharp pain in the side and a bloody vaginal discharge, which may be of a shreddy nature. The abdominal hemorrhage may be enough to cause a mild degree of shock and the attacks of pain are repeated from time to time as fresh bleeding occurs. Strange to say, shock may take place when the bleeding is very slight. These are the cases which are occasionally mistaken for miscarriages, and if they are curetted, alarming or even fatal hemorrhage may follow from traction upon the uterus, thus displacing the clot in the bleeding vessel.

If there be any serious doubt as to the differential diagnosis in a patient about to be curetted, preparations should be made for an abdominal section at the same time.

Usually it is needless to confuse a miscarriage with an ectopic pregnancy, as the physical signs and especially the pains are unlike. Pains accompanying a miscarriage resemble somewhat a miniature labor and intervals between pains are more or less regular, while with ectopic pregnancy the pains are irregular, being sometimes almost constant and at other times hours apart.

If with the above history and symptoms, a mass is found in one side of the pelvis which is very tender and the uterus does not correspond in size to the supposed length of pregnancy, the diagnosis is usually positive.

One of the difficulties in making a positive diagnosis is

due to the fact that there may have been pathology in the pelvis previous to the present attack. An old inflammatory mass or a small adherent ovarian cyst may simulate the mass of an ectopic pregnancy. Dragging of the growing uterus upon the adhesions is the only way I can account for the symptoms of these complications. On two occasions I have been misled by the presence of a small adherent ovarian cyst. Both cases were minus the important symptom of bleeding (as they were very early in the pregnancy) and we expected to get the mass before rupture. One was my first private abdominal operation and a very interesting case. Both were, however, surgical cases, and the operation at the time was very opportune which is, of course, of prime consideration from the patient's viewpoint.

In all surgical work, whether in the pelvis or elsewhere in the body, we should be sure there is a surgical lesion present and then no harm will be done, except to our pride. No one likes to make a mistake as to the exact nature of the pathology present in a given case. On the other hand, failure to operate may lead to disaster.

I think there is little divergence of opinion as to the treatment of ordinary ectopic pregnancies. Few would do otherwise than to operate once the diagnosis is plain.

There are those who would, in an acute alarming hemorrhage with much shock, treat the patient expectantly until recovery from the shock, thinking they would thus stand the operation better. These surgeons claim that patients are not likely to die from the first hemorrhage as the blood pressure will finally get so low that a clot will form and the bleeding cease for the time being. While in some rare cases it may be expedient to wait a short time, I fancy not many of us would care to take this chance in our own abdomen were we positive the bleeding point could be reached and controlled within five minutes after making the abdominal incision. We have all known of patients who did die under these circumstances.

On the other hand I cannot recall a patient who died when operation was performed, even when she was almost moribund.

It is remarkable what results may be obtained by operation in the presence of an uncomplicated hemorrhage. I mean by this when the patient has not, previous to the bleeding, been the subject of some debilitating disease. There is,



of course, a limit to the amount of blood which can be lost. Infusion will help up to a certain point after which transfusion will be necessary. My advice would be then, to first secure the bleeding point and then infuse, preparations for which may be made before the operation begins. If done before the bleeding point is secured the increased blood pressure will likely start the bleeding again.

When the bleeding from the rupture is slow and a clot forms we may take a little more time, but even then the sooner the operation is performed the better as we never know just what is going to happen next.

Cases of tubal abortion may not be so dangerous to life, but I would say, treat them all alike.

1925 Chestnut Street.

#### DISCUSSION.

DR. JOHN E. JAMES, JR. opened the discussion as follows: Apropos of some of the remarks, at the same time carrying a certain moral worthy of our attention, I wish to mention the most unusual case of Extra-uterine pregnancy I have heard of. The incident is given me as bona fide by a professional associate. A young woman with suspicious symptoms, presented herself to a physician who promptly diagnosed a tubal pregnancy and advised immediate operation. Subsequently, after the patient had been delivered of a full-termed baby through the natural passages, further light upon the previous condition and operation was sought. Upon interrogating the surgeon, he informed the patient he had found a pregnancy in the tube when he operated and that he had carefully dissected out the pregnant mass, opened the uterus, implanted the mass in the uterine cavity and thus permitted her to carry her child normally to term.

There are many cases operated for tubal pregnancy where the same procedure might be of advantage to the surgeon were it possible for him to possess such unique skill and spiritual powers.

Dr. Lane has mentioned quite concisely the more salient points in connection with a brief consideration of such a big subject as Extra-uterine pregnancy.

I would call your attention to the following and ask but a moment of your time in a short elaboration.

1. The period of relative sterility.
2. The indefiniteness or extreme variation observed in subjective and objective findings in most cases; making a

positive diagnosis before one of the usual terminations occur a matter of difficulty.

3. Clinically, there are two classes of cases:

(a) the acute—that of tubal rupture.

(b) the subacute—that of tubal abortion.

4. The easy confusion in the differential diagnosis between early uterine abortion and tubal pregnancy.

5. The necessity of immediate operation in all cases.

The frequency with which we obtain a history of a comparatively long interval of sterility serves to emphasize pelvic inflammatory conditions as the usual etiological basis. Extra-uterine pregnancy can occur as the result of mechanical agencies, those due to associated tumors or developmental abnormalities of the pelvic organs, and in a normal pelvis, due to embryological causes; these cases are rare compared to those dependent upon the end-results of pelvic infections, venereal or puerperal. Be unusually suspicious of every case where relative sterility has been present.

2. Practical experience demonstrates the rarity with which we meet with cases of ectopic pregnancy closely conforming to the classic or text-book picture.

I have observed an extreme variation in the menstrual histories; from those where there has been absolutely no amenorrhoea to those in whom there has been complete amenorrhoea (over the third month). Careful questioning will, however, usually elicit some irregularity in menstruation for the individual case.

The uterus invariably will show a comparative enlargement with the "softening" signs of early pregnancy; the associated "lateral mass," however, varies exceedingly in size. The "sausage-shaped" enlargement we hear of frequently only is present after intratubal bleeding takes place (a preliminary phase of tubal abortion.)

To me it is folly to look for decidual remnants in the vaginal flora as a diagnostic feature in an untermiated case. The uterine decidua remains undisturbed until either abortion or rupture occurs; when other and much more important diagnostic conditions are manifested. Any attempt to probe or curet a uterus to obtain decidual pieces for confirmatory diagnosis should be most highly condemned.

3. The extreme rarity of ovarian and abdominal (primary or secondary) pregnancies permits us to use the terms extra-uterine pregnancy and tubal pregnancy interchangeably. Also, for obvious reasons, it is rare that a tubal pregnancy is recognized before one of the usual terminations occurs.

Hence, we speak of the two clinical types—rupture and abortion.

The case of rupture needs no comment. Tubal abortion needs emphasis because it is rarely considered; cases of this character are usually thrown into the diagnostic junk-heap of "pelvic mass" and the operator is surprised when he finds and removes a "haematosalpinx;" and especially, because it is *the most frequent* termination of tubal pregnancy.

4. The confusion in differential diagnosis, more than probable, between a case of threatened uterine abortion and tubal pregnancy, each with the history of a supposedly normal pregnancy, bloody vaginal discharge and vague abdominal and pelvic pains, emphasizes the necessity of subscribing to modern obstetrical teachings; early, thorough, routine examinations and strict observance of ante-natal care.

5. We all must agree to the dictum of immediate operation. The only issue I would raise in this connection would be in certain moribund cases—those of rupture with the classic picture of shock in extremis. To a large extent, necessarily, this picture is dependent upon the intra-abdominal hemorrhage, sudden and severe in character; however, I do thoroughly believe that the shock is added to by a certain vaso-motor disturbance associated with the rupture and bleeding. Consequently, in the unusually severe case I believe it is reasonable to "stimulate" the patient with morphia, treat for shock, and as soon as some improvement is noted, operate and control the point of bleeding. In all of these cases, do not forget the value of a pint of hot normal salt solution left in the abdominal cavity.

DR. THEODORE J. GRAMM: Dr. Lane is entitled to commendation for this clear and concise statement of most of the facts relating to ectopic gestation, and I am quite sure it is safe to accept his views and to follow the treatment proposed.

Ectopic gestation has interested me for many years. There was a time when it was little more than mentioned in the didactic course; but the advances in gynecology, upon which so many successes in abdominal surgery directly rest, have changed all this. A little later our attention was directed to pelvic hematocele, and the finding of this collection of blood in the abdomen brought about much discussion of the etiology and pathology involved. The theory was proposed that the blood of menstruation flowed backward through the tube and found its way into the peritoneal cavity; or that from some cause bleeding occurred from the pampiniform plexus or from some other ruptured vessel. Gradually, however, our views



became focused, and just as the vague teaching concerning perityphilitis narrowed down to that little appendage of the caecum, the appendix, as the starting point of that frequent and serious inflammation in the right iliac fossa, and we then spoke only of appendicitis; just so our view was directed to the uterine tube and the accident which there occurred as the result of the ovum being detained and developing there and causing in many cases this collection of blood, associated with pain and shock; and we now speak of ectopic gestation. Much of the work of clearing up this subject was done abroad, I regret to say, although Parrish has made an admirable contribution to the subject, and his book is well worth reading to-day.

The diagnosis of ectopic pregnancy is sometimes very easy, and I can well believe that someone may have said that there is no excuse for failing to recognize a case. These generalizations really cause trouble occasionally. Even so wise a man as Solomon once said that all men are liars—which at times we are all inclined to believe to be true, present company excepted, of course. But then he hedged a bit, and said he had only made the allegation in his wrath. In the same way I presume the doctor referred to made his generalization in his enthusiasm.

It has just been said that ectopic pregnancy is not rare, and we must keep our minds alert to its occurrence. The late Dr. E. R. Snader and I once had a discussion on this very point, and we came to the conclusion that alertness to its likelihood was the proper mental attitude. Strangely enough, however, after our attention has been forcefully drawn to a certain disease we are apt to think we recognize many cases which do not exist. Thus some physicians have sent many cases to the hospital for ectopic gestation, and it is only necessary to do so often enough to make some brilliant diagnosis. The same is true of the young interne who has faithfully studied fibroid tumor of the uterus, which so often occurs in the black race. When the negress comes to the hospital to find out what is the cause of this quite unexplainable enlarging abdomen, the diagnosis of fibroid uterus has been made; and it might have been correct, only that the fetal heart sounds were audible, and the patient had unfortunately neglected to mention that she has a friend. We have probably all encountered the woman who comes into the sick room and insists the patient will die when there is no evidence to so suggest. When the patient actually dies we are told why, of course, I told you so two weeks ago. I know of a strange incident where a young woman once persistently insisted that her normal and normally

born babe would die, and it did so within the first few days. I never did know the cause, except the evil influence upon the quality of the milk induced by excessive and constant alarm.

Dr. Lane has referred in really a fine way to our mistakes. As long as men are fallible, mistakes obviously will be made. Thus there were once three distinguished surgeons and physicians who required many pages of a medical magazine to explain away the fact that not one of them recognized the diagnosis of a case until fetal bones were being passed per rectum. A widely known surgeon and gynecologist positively refused to confirm the diagnosis of an easily recognizable unruptured case, although the evidence was repeatedly pointed out to him, together with all the classical signs. On another occasion a professor of obstetrics and a general practitioner of much experience observed a woman for three days and two nights while she endured the spurious labor which marks the termination of a full time ectopic pregnancy; and when the pains ceased at the death of the child, both these gentlemen concluded the patient had miscalculated her time. Then there is the story of that operator who had not given much attention to ectopic gestation, but shortly after it had been called to his notice, claimed to have thirteen cases at one time, and his ward held precisely thirteen beds.

Some remarkable observations may be made in gynecological practice. There is retroversion, for example. We cannot now discuss the pathology of retroversion, but many cases are associated with menorrhagia, and occasionally with metrorrhagia. Now suppose that two cases are encountered with some atypical bleeding, and are promptly relieved by replacement, together with other treatment; and then a third case comes along having no recognizable lesions lateral to the uterus and the patient is treated in much the same way—and then let us assume that in about three weeks the patient exhibits the signs of ectopic pregnancy—why, of course, the doctor will be blamed for not recognizing a condition which had not yet produced its signs. Therefore, Dr. Lane has well stated that conditions and symptoms change, and a physician may see a case at a more favorable time, whereas had he been called when the first doctor saw the case he probably also would have been misled.

Conditions in gynecological practice sometimes change with remarkable rapidity. I saw a case recently who had an antelexion (I do not often make that diagnosis), together with a small sensitive mass at one side of the uterus. There was no obvious cause to explain this woman's atypical uterine flow, which had continued at times for a very long time—

many months, as I remember, for she had been treated for it by three physicians at various times. When I saw her today in the out-patient department, the small sensitive mass could not be found; but the uterus was no longer flexed and was distinctly enlarged, and on the other side was an undefinable, rather large mass, not hard. That case was immediately urged to enter the hospital, and I shall not be surprised if a friend now on duty in the ward, will be called upon to operate her for ectopic pregnancy.

To offer some theoretical explanation for such cases it might be assumed that salpingitis existed, and this might possibly explain the irregular bleeding. Being recent on one side, it was more sensitive to touch there. For some reason, possibly from treatment, this side improved, and the sensitiveness disappeared. The salpingitis, likewise present on the other side, may perhaps have arrested an impregnated ovum, the uterus enlarging sufficient to remove the flexion. At any rate, a mass rapidly developing, not present two weeks ago, is sufficient reason for closely observing such case in a hospital ward. Of course, an increasing collection of pus might explain the case.

The signs and symptoms of ectopic pregnancy have been much discussed. I believe they might be more clearly stated, some magazine articles seeming rather to becloud the subject. I believe, too, that we are better prepared to recognize the symptoms when we remember what changes are taking place to produce them. Briefly they are as follows: While the ovum is slowly passing along the tube it may be arrested there and then continue to develop, while the villi of the chorion enter the adjacent tissue and fully establish the parasitic status of the ovum. When the process has reached a certain stage of advancement, that is to say, somewhere from the eighth to the twelfth week, a rupture of the tube occurs, or if situated near the fimbriated extremity it protrudes from the tube end and a tubal abortion is imminent.

The site of the ovum, together with the direction of the rupture, determines the gravity and distinctness of the symptoms. If the rupture occurs downward between the enveloping folds of peritoneum which go to form the broad ligament, the abdomen is not found full of blood at the operation, but a haematoma is formed, and the woman, though having pain does not exhibit so serious symptoms of shock and internal hemorrhage as when the rupture takes place along the free border of the tube, or bursts forth into the peritoneal cavity from the large, dilated and congested fimbriated extremity. I possess some beautiful specimens showing these various ways



of rupture. One in particular displays the translucent fetal membranes protruding from the dilated tube end, while the fimbria grasp the globe of the ovum.

The classical symptoms of ectopic pregnancy, as I remember them off hand, may be summarized as: A previous period of sterility; one missed menstrual period; atypical metrorrhagia; symptoms of suspected abortion; decidual fragments containing no chorionic villi discharged from the uterus; slight enlargement of the uterus; crampy pains in the abdomen; a mass lateral or posterior to the uterus; rupture at the eighth or twelfth week, attended by pain, shock, syncope.

The microscope may give valuable aid in determining an important sign, as I demonstrated before this club some years ago. As we all know the chorion is a fetal contribution to the structure of the placenta. When, therefore, we examine under the microscope these shreddy membranous fragments passed from the uterus during the atypical hemorrhage, they will be found to consist only of decidua, and contain no trace of chorionic villi. On the other hand, when the specimen is examined after operation, chorionic villi will be found in the clots or tissues of the tube from the site of the developing ovum. If chorionic villi are found in the fragments from a case of atypical uterine hemorrhage, the case is one of incomplete abortion—and, by the way, speaking of mistakes, it is *not* a case of tubular carcinoma, as a pathologist wrongly diagnosed not so very long ago.

There is much to be said about this whole subject of ectopic pregnancy which cannot be touched in this discussion, but in conclusion, I would endorse the treatment proposed, and express my pleasure for having heard Dr. Lane's excellent paper.

In closing the discussion Dr. Lane recited two cases to illustrate the different varieties of the subject under consideration and also spoke of the treatment of those rare cases which rupture into the broad ligament.

**SEPTAL DEVIATIONS—THEIR CAUSE, EFFECTS AND CORRECTIONS.**

BY

CHARLES H. BEEBE, M.D., PHILADELPHIA.

SEPTAL deviations have been known for many years. There are various opinions as to their cause. The most generally accepted theory is that the septum is straight in 80 per cent. of people up to about the seventh year, when as a result of accident, blows or falls, many acquire the deviation. In adult life fully 75 per cent. have a deflexion of some sort, the majority being to the left.

We find many kinds of deviation. They range from a simple curvature to double curves simulating the letter S or its reverse. They often obliterate the entire breathing space on the side of the deviation, causing intense pressure on the turbinates, affecting the mucous membrane and setting up chronic inflammation and finally atrophic degeneration of membrane and a shrinking of the turbinate on which the pressure is exerted. As a result of the occlusion we may have numerous sequelae, as eustachian or tubal catarrh, followed by middle ear catarrhal inflammation and also a certain amount of deafness. Many acquire sinus disease on the side of the deviation.

The deviations occur in the descending plate of the ethmoid bone and in the cartilaginous part of the septum and are often complicated by a spur or ridge from the vomer. We may have them in the antero-posterior direction, the anterior bending from above down, also a vertical convexity. The S-shaped or sigmoid deviation in which the anterior portion projects into one naris and the posterior into the naris of the opposite side; some have the deviation assuming many shapes as a result of traumatism; some in which the cartilage entirely fills the nostril of one side and may press on the inferior turbinate of that side giving an entire occlusion of the nostril. Considerable deviation may take place without interfering to a great extent with the breathing or drainage, although a deviation may be so great as to render respiration on the deflected side impossible. Also spurs may impinge on the tissues of the lateral walls causing pressure and inflammatory symptoms. Deflexions exert pressure on the middle turbinate bone and push it upward and outward.

Many theories have been advanced as to the cause of septal deviations and deformities. The main causes are:

- (1) *Congenital*, which are rare.
- (2) *Arrested or over-development* of the facial bones.
- (3) *Traumatism*, which accounts for the majority of deviations after the seventh year. This may occur from a fall or blow.

**PATHOLOGY:** When the irregularity is due to a spur it is either cartilaginous or bony. The cartilaginous is generally in the anterior part of the septum, "a bulging or thickening of the nasal cartilage." If bony it is mostly posterior or on the floor of the nasal cavity. A spur may cause obstruction to nasal breathing, especially if it impinges on a turbinate bone, but usually it is not of much hindrance unless complicated with septal deviation. When the deviation is due to traumatism, the changes in the perichondrium and periosteum may result in localized thickening as a result of the inflammatory condition produced by the traumatism, and may cause attacks of catarrhal and purulent inflammation of the nasal mucous membrane often extending to the nasal sinuses.

**SYMPTOMATOLOGY:** This varies according to the degree of septal deformity. Slight deformity may produce no symptoms. When there is a marked deviation, you may observe an extensive deformity on the side of the convexity. You have symptoms of obstruction, difficulty or inability to breathe through the obstructed nostril, causing mouth breathing at night or during exercise.

Catarrhal inflammation sooner or later develops behind the obstruction. First of the mucous membrane of the nose, then by extension through the pharynx and larynx to the lungs and in many cases to the bronchi, causing a discharge of mucous and cough, an alteration of the tone of the voice, and periods of chronic atrophic rhinitis with the accompanying crusts and hyperplasias, foetid breath, headache and susceptibility to colds, loss of smell, and all the symptoms of chronic nasal atrophic rhinitis. May also have from the pressure of the deviation, headache, asthma, neuralgia, or hay fever susceptibility.

**DIAGNOSIS:** Examine by first applying a mild solution of cocaine, then adrenalin, as it gives a better view of the passages. Then with a speculum, and good reflected light from



a head mirror, and by examining both nostrils you can readily see the deviation and also the extent and position of the flexion. You will find a convexity in one nostril and a corresponding concavity in the other, on the concave side the inferior turbinate bone is swollen or hypertrophied; at times the deviation is so well marked that the entire nostril is blocked; the septal cartilage may be split and spread causing the occlusion.

**TREATMENT:** There have been many kinds of operations for the correction of the deformity, viz.: The Ash operation and later, and probably the best, is the so-called submucous resection in which the mucous membrane of the nose is first cocaineized, then a Schleich solution consisting of morphia, cocaine and adrenalin in a normal salt solution is injected between the mucous membrane and cartilage and bone of the septum in both nares until a well marked white blister is observed on both sides of the septum. The membrane is then incised at the lower part of the cartilaginous portion, a separator is introduced between the cartilage and the bone and the mucous membrane, which is thoroughly separated on the side operated, preferably the convex side. Then an incision is continued through the cartilage to the other side, being careful not to cut through the mucous membrane of that side; then separate as on first side. The cartilage is removed by a swivel knife, after placing the blades of a nasal speculum on either side of the cartilage, then the broken, bent nasal bones, causing the deviation higher up are removed by nasal bone forceps. If there is a spur on the vomer it is then removed with a chisel. The mucous membranes of both sides are brought together, and both nares packed with gauze. The packing is removed in about forty-eight hours, the nose is examined and if there is no bleeding it is not again packed. The patient will find the greatest relief, being able to breathe well and in time many of his old symptoms disappear. There is not much bleeding in the majority of cases, and not much pain attending the operation. It is well to give aconite to control any rising temperature that might follow the operation. The patient's temperature should be taken for twenty-four hours to see if there are any signs of infection.

**THE RESPONSIBILITY OF THE ANAESTHETIST.**

BY

EVERETT A. TYLER, M.D., PHILADELPHIA, PA.

Anæsthetist to the Hahnemann Hospital, Philadelphia.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, September 17, 1919.)

THERE was a time when the administration of an anaesthetic was looked upon as a trivial affair. In fact, there are physicians to-day who are not yet emancipated from that ancient obsession. Nurses, after having had a few weeks' training in dropping ether, are permitted in this and some other States to receive remuneration from the practice of this branch of surgery, in open violation of the law governing the practice of medicine. The opinion held by some men that the aforesaid nurses make competent anaesthetists might be correct, provided the work of the anaesthetist consisted solely of the mechanical dropping of ether. Unfortunately for the proponents of this opinion, who frequently are the men who know the least about this subject, the leading anaesthetists of the world agree, that the anaesthetist is responsible for more than the mere mechanical administration of the anaesthetic agent.

The one who essays to preside at the head of the table during the operation, should be capable of assuming the responsibility of the preoperative examination of the patient. Of course, the ideal condition would exist, if we could have every patient go through an examination as given at the Mayo Clinic. In time this will obtain in all large cities. The next best is to have every patient examined by an internist and a laboratory man. Unfortunately, even the latter is impossible in at least 90 per cent. of the cases. Most surgeons do not, and some cannot, make the examinations, so it is evident that the anaesthetist must be so trained that he can make these examinations himself. He should, therefore, make as complete an examination as possible, the minimum at least to include: The age; the psychic condition of the patient, especial attention being given to the likes and dislikes pertaining to the anaesthetic agent; and the presence or absence of fear in order to forestall psychic shock; the blood pressure, in order to determine by "Moot's Rule" the possible prognosis; the condition

of the heart, lungs and kidneys. The surgeon should next be consulted as to what operative procedures are to be undertaken. Taking all the above facts into consideration, the anaesthetist will then determine what anaesthetic agent is to be exhibited and by what method it is to be given. He should then order the necessary medication to combat psychic and surgical shock and acidosis.

When the patient comes to the operating table, the anaesthetist, knowing the technique of the operation, the reflexes involved and the stage in which they are abolished, will determine and maintain the degree of anaesthesia commensurate with the patient's condition and the needs of the surgeon. In parentheses let us say that good teamwork here between the surgeon and the anaesthetist will work to the benefit of all concerned. By constant attention to the color, respiration, pulse-rate and pressure, the latter either by palpation or frequent use of the sphygmomanometer, the anaesthetist will be able to warn the surgeon of approaching danger, and to inform him how much time can be consumed in completing the operation without undue danger to the patient. If necessary, the anaesthetist will order the medication to combat the emergency.

It is almost trite to state that the anaesthetist should see that his patient is properly returned to bed, and that a competent person is put in charge of the patient for the period of return to consciousness. It is essential that this person know how to maintain an open airway. The anaesthetist should now be consulted as to treatment and medication necessary for the general condition of the patient, especially following an intraoperative emergency, because the anaesthetist will have had the opportunity of better observing the effect of the medication ordered while the patient was on the table. Even if none has been used, the anaesthetist is the only one who has been in intimate touch with the patient's true condition during the operation, and, therefore, is the better able to judge what medication is necessary.

Here the responsibility of the anaesthetist ends, and he can turn the entire charge of the patient over to the surgeon, unless a postoperative complication should arise for which the anaesthetist is responsible. In which case the anaesthetist would certainly like to be consulted.

In conclusion, we believe, as the leading anaesthetists do,



that the responsibility of the anaesthetist includes all that we have outlined above; furthermore, if this is granted, then it follows that a complete medical education is the minimum prerequisite for an anaesthetist.

DISCUSSION ON DR. TYLER'S PAPER.

DR. H. L. NORTHROP, Philadelphia: A paper on Anæsthesia is always in order. The question of giving an anæsthetic is as live a question to-day as it was fifty or one hundred years ago. It is not much less than one hundred years since ether was first administered, or since the anæsthetic properties of chloroform were first discovered; yet to-day, the responsibility of the anæsthetist is as great and the risk to the patient is as great as it ever was. He would ask Dr. Tyler whether he thinks that there are as many deaths now under anæsthesia as there were one hundred years ago.

DR. EVERETT A. TYLER, Philadelphia: There are many deaths occurring to-day under anæsthesia. Many are not reported. There has been an increase in the number of deaths under nitrous oxide, but it is difficult to get the proper statistics. It may be that the percentage of deaths has not increased, because the number of administrations is increasing every year. The increase in the use of nitrous oxide in dental work has been tremendous. Of the deaths under the newer forms of anæsthesia, perhaps spinal anæsthesia can claim the greatest number. He thought that there are more deaths under anæsthesia to-day than there were twenty-five years ago, but not more under ether than there were twenty-five years ago; because ether is the safest anæsthetic, and an untrained person can do less damage with it than with some other anæsthetics.

DR. H. L. NORTHROP, Philadelphia: Dr. Tyler has put it well in saying that while more deaths occur to-day under anæsthesia than formerly, the relative number is smaller. Yet the administration of an anæsthetic certainly is to-day, with all our skill and experience, and with all the refinement of material, a very serious matter; and Gwathmey himself has spoken of the very great danger of nitrous oxide, and has warned the anæsthetist against the promiscuous and careless use of it. So we ought to take all precautions, and employ the best men that we can get, men who make a specialty of it, if possible; or, at least, those who give anæsthetics so frequently that they are qualified and skilled. In this way, we can safeguard our patients, and in no other way. We are all surprised, at times, and

then we regret that we have not been more particular. In this part of the country, chloroform is under the ban, and has been for many years; and in other parts of the world, where it was much used formerly, it is not so much employed to-day.

The most dangerous anæsthetic is the one injected into the neural canal. Next comes chloroform; and then the least dangerous, ether. Yet we should not entrust the administration of ether to Tom, Dick and Harry. We should employ a man who knows how to give it.

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### AMPUTATIONS, THE PREPARATION OF THE STUMP AND THE FITTING OF THE ARTIFICIAL LIMBS.

BY

JOHN A. BROOKE, M.D.

(Read before the Pennsylvania State Homœopathic Medical Society, Sept. 17, 1919.)

FORMERLY in dealing with amputations our chief concern was in following out some time honored method and having large and generous flaps. At present, after observing and treating a good number during this past year our views are somewhat altered.

First, we consider the utility of the stump and the way it can be best fitted with an appliance that will in a large measure take the place of the amputated member. The time honored amputations are not the ones in most instances that enable the patient to wear the neatest and most useful prosthesis. Many of the well known amputations of the leg for instance came into favor before we had any of modern and cleverly devised artificial legs to substitute for the loss of the leg. Surgeons generally had the idea that a stump must be able to bear weight upon its end. For years this idea dominated the surgical procedure. We remember the short amputations below the knee, how the stump was flexed at a right angle with the knee, in this position the patient put his weight upon the peg leg. The amputations at the knee joint, ankle joint or through the tarsus will permit of end weight-bearing but they are hard to fit and require big cumbersome apparatus. They are very unpopular with the artificial limb makers for this reason.

A patient with an amputation at the lower and middle third of the leg, properly fitted with appliance, will walk

better and with less limp than the patient with an amputation at the ankle, a Syme's amputation or one through the os calcis, a Pirogoffe amputation, or a Choparts through the tarsus. The success with which a patient uses an artificial limb depends not alone upon the level of the amputation but in a large measure upon the condition of the stump, its smoothness and freedom from pockets and irregular depressions, the position of the scar and if adherent to bone, the sensitiveness of the stump due to painful nerve endings, whether sinus exist and sequestra are present.

A decision as to the best levels for amputation presupposes a certain knowledge on the part of the operator of methods of fitting artificial limbs and of the ways in which the stump communicates movement to these. Big flabby muscular flaps are undesirable, they do not fit the socket of the appliance well; they are wabby and unstable. The best covering for the end of the bone is a small layer of fat, subcutaneous tissue and skin.

The aperiosteal method of dealing with the bone is the most satisfactory. Osteophytes and spurs which are often painful are common around the end of the bone. These are likely due to the shredding of the periosteum which should be removed one-quarter of inch above the bone section and the medulla curetted the same distance.

Many amputation stumps are painful. A good many of these have a definite tenderness over the enlarged ends of the main nerves or a neuroma along their trunk near the end. The axis cylinders grow out from central end. If there is no peripheral end for them to grow into they coil about in the immediate neighborhood and form a neuroma or spread out in other tissues. There are two methods of treating and preventing these neuromata; either by crushing the nerve with a clamp and ligating, thus keeping axis cyl. within the sheath or by stripping back the sheath, dividing as high as possible and drawing down end of sheath and ligating it.

In our army experience we were struck by the great number of amputation cases that reached us that needed secondary operations—this same condition existed with all the World War combatants. In some French statistics 20 per cent. of healed leg amputations showed excellent stumps. 70 per cent. had terminal scars and 50 per cent of these were adherent to



the bone. We realize that these cases were treated during the strenuous days of the war when the surgeons had little time to think of finished work but only of the life of the patient. Then too, most all these cases were infected, which would only permit of a guillotine amputation or one with wide open flaps. In the face of these conditions these end results are very creditable.

The application of skin traction to the guillotine amputation and others where the flaps have been left open, is of greatest value, especially in thigh and upper arm cases. The amount of retraction of muscles and skin is often remarkable. By using extension to the skin these soft tissues may be brought down to cover the end of the bone and save any further shortening of stump. Traction may be applied by a pulley and weight or by a modified Thomas splint using either adhesive plaster or flannel strips and glue.

In the preparation of the stump for the wearing of an artificial appliance notation was first made of the length of stump and if wound was completely healed. If open or if sinus were present whether a osteomyelitis existed or a sequestum could be found. Every stump was radiographed and the condition of bone noted. Many otherwise normal bone ends showed large spur formation. When an open wound existed skin traction was applied for two or three weeks; if an osteomyelitis were present, the diseased bone was cleaned out and the wound Dakinized. Sequestra were removed. The keynote in this part of the treatment was conservatism, a policy of watchful waiting, always fearing to light up the old infection and trying in every way to avoid further shortening of the stump. If the stump was healed the position of the scar was noted. A terminal scar will give little inconvenience in the arm even if adherent but if on the side or in the front of the stump it may be sensitive and become irritated and necessitate excision in order to comfortably wear an artificial arm. In the leg a terminal scar stretches and breaks down continually when the circumferential pull of the artificial limb bucket is put upon it. Many healed cases present uneven flaps with projections and sulci which become irritated and inflamed when an artificial limb is worn. In these cases we resorted to plastic operations, excision of scar, removal of redundant skin and soft tissues endeavoring to get a smooth even surface.

Just as soon as the stump is healed effort is made to harden and toughen it so it can stand the wear of the appliance. Exercises are given to the stump to keep up the muscular power and secure a full range of motion, for contracture usually follows especially at the hip, knee and shoulder joint and these greatly interfere with the use of an artificial limb. The stump is given hydrotherapy, then massage and stump pressure starting with slight contact against a pillow then increasing pressure and pounding until the patients can bear : padded seat without the slightest pain.

Even before this has been accomplished, it is advisable to start the patient with a provisional appliance. Many months elapse, from 6 to 10 months or a year, before shrinkage of the stump is complete and a permanent artificial limb can be worn. During this time the patient fully realizes that he is a cripple, that he has to go through life with a handicap. He is not apt to take up any work, his muscles atrophy and if he has lost a leg he forms the crutch habit. The temporary artificial limb greatly aids in maintaining the muscular tone, it hastens the shrinkage and causes the limb to assume a permanent shape. It allows the individual to begin some useful work, he doesn't develop a mental inertia nor feel he is so much a cripple. A temporary prosthesis for the arm usually consists of a leather socket, side irons and forearm extension to which a hook or hand with flexed fingers is attached. For the leg we use first a plaster socket attached to a crutch pylon or peg leg, then a fibre or metal leg with knee and ankle motion.

To secure the best results and develop a greater proficiency in the use of an artificial arm or leg it is necessary for these patients to have some training in the use of the appliance. They will then realize what they can accomplish by persistent effort. With the arm amputations certain games are played and work given that brings in use the prosthesis. In leg amputations, instructions are given as to the position of foot upon the ground ; how to walk up and down stairs of varying lifts, how to walk on an incline, in sand stretches and over obstacles and small hurdles.

We feel sure if these principles are applied to our civil practice we will find that a larger percentage of our amputation cases will be wage earners and able to fight their own battles of life, regardless of their handicap.

## EDITORIAL

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### ON BEHALF OF THE NEW HEALTH OFFICER.

WITH the advent of a new civic administration in Philadelphia there will be new brooms in a number of our municipal departments; and, in the public mind, there is evidence of a more than usual hopefulness that at least some political rubbish will be swept out of City Hall.

Aside from a general interest in an honest, business-like administration of public affairs, the medical profession has its attention especially directed on the Department of Public Health, and its new executive officer. Dr. Furbush brings to this position many special qualifications together with an army experience which is of particular value. For an illustration of what can be accomplished to safeguard the health of a community we need go no further than to recall the wonderfully efficient work accomplished by General Wood, *when he was given the absolute power to accomplish it*. There is an especial significance in this italicised sentence which should be very clear in the public mind; for unless it is plainly understood, failure in efficiency may be easily charged to the new director when in reality it is due to the systematized limitations which may surround and subvert the performance of his duties—limitations which are an integral part of an imperfect or rotten municipal system.

For instance, it is obvious that the Department of Health should have ample endowment; yet we have heard of certain public nuisances which could not be abated, and the astounding excuse offered that there were insufficient appropriations for this purpose. Again, there is a strong public impression that other violations are discreetly ignored because of political "pull." Furthermore, there are other infringements of the plain laws of health which if radically attacked would affect a powerful class of advertisers in the daily press, and likely bring a storm of editorial opprobrium on the luckless director. To this class belongs the unsanitary conditions which prevail in



even some of our best restaurants, and the careless and inefficient cleansing of eating utensils—especially forks and spoons, and that ubiquitous rag in the hands of the waiter. With this must be included the practice, all too common, of food stuffs and dirty money being handled by the same unwashed hands. One need not go far from City Hall to observe a clerk in a large establishment handling money and making change with the same unwashed hands with which he slices and fingers tongue, ham, sausage, etc. Perhaps one can imagine the howl of invective which would be heard were radical reforms insisted on in these numerous and powerful establishments; and might not the uncomfortable pressure on the mayor and his administration soon cost the over-zealous appointee his job? Is it possible that the dirt and dust nuisance so obvious in our highways must be soft-pedalled lest certain powerful political bosses, who are also contractors, be provoked and spill their venom? The merest tyro in medicine knows absolutely that our crowded and unventilated street cars and trains are the greatest disseminators of infectious disease; yet is it expedient to offend great corporations by insisting on adequate car service which will do away with sardine box crowding and provide for proper ventilation? Of what use is it to placard the cars and “kindly request” passengers to “keep the (so called) ventilators open,” and not to “spit on the floor”? If it is clear that these precautions are necessary to public health, why not correct them at the source, and not depend on the acquiescence of a medically ignorant public which is taught a whole lot about Moses in the bullrushes, but precious little concerning things of vital interest to municipal health and personal comfort?

There are but a few reflections concerning the by-no-means-to-be-envied job of Director of Public Health. A remedy would be to make this official an elected appointee for a long term, and removable only for just cause after judicial inquiry. He should not be removable from office at the whim of a mayor, and his powers to enforce established and necessary sanitation and health conservation should be absolute.

We must not blame a health officer for supposed defecations, without first ascertaining to what extent his hands are tied in the complicated entanglements of political red tape. When General Wood cleaned things up he had military authority, military backing, and his word was law. The outcome is

a matter of history. Granting equal efficiency and equal zeal, a civilian appointment is quite another matter.\*

W. D. BAYLEY.

\*That which has been said with particular reference to Philadelphia applies with equal force to all other civil communities. General Butler's cleaning up of New Orleans during the Civil War has long been a famous example of military efficiency in health matters. In small municipalities, health officers, usually physicians, give many hours of service for very small pay. In many instances the work is performed ungrudgingly without any remuneration whatever. With but few exceptions this unselfishness fails of appreciation on the part of the community at large. Too often it is wrongly assumed that inasmuch as the health officer receives no pay, he makes up for the deficit in other ways, i. e., graft.

The new Health Officer in Philadelphia, Dr. C. L. Furbush, comes to us with exceptionally good training, having had large experience in both civil and military affairs.

C. B.

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#### THE VALUE OF MEDICAL SOCIETY AFFILIATION.

LAST month we directed attention to the importance of the county medical society as part of the medical organization. We also announced editorially that Dr. Thos. H. Carmichael, as Chairman of the Committee on Pharmacopoeia of the American Institute of Homœopathy had secured for the homœopathic physicians of the United States the privilege of securing, without bonding, annual quantities of alcohol for professional purposes not in excess of fifteen gallons. The fee charged by the bonding companies for the service is five dollars. To be practical, every homœopathic physician in the country is saved five dollars (which happens to be the annual Institute dues) by reason of the success of the efforts of Dr. Carmichael and his colleagues. While the work was performed by them as individuals, there can be no question about their success being due to the fact that they represented a large and dignified national society of physicians. As the Institute has somewhat more than 4,000 members and there are 12,000 homœopathic physicians in the United States, it is plain that two-thirds of the latter are reaping the benefits of the labor and loyalty of the remaining one-third. The moral is obvious. Each reader of this article, who is not already a member, should apply at once for membership in the Institute, accompanying his application with a check for five dollars, drawn to the order of the Secretary-Treasurer, T. E. Costain, whose address is Marshall Field Building, Chicago.

A standard argument to induce physicians to join their societies is the financial benefits accruing to them by reason of the existence of these organizations. Unfortunately, we are seldom able to bring forth a concrete instance where the relation of cause and effect is so obvious as in the instance which we have quoted. Unfortunately, the benefits accrue to all physicians alike; thus it is that men of selfish instincts prefer to be slackers enjoying the benefits of the loyal and giving nothing in return.

It cannot be denied that medical societies have ever been watchful of professional interests, and were it not for their existence, medical practice would be in a sorry plight. Moreover, their members have always acted unselfishly, their sole rewards being that of the pleasures derived from success.

We have always been interested in the matter of improving the numerical strength of our societies. We have met with "hold backs" whose stock argument is that "so-and-so" runs it. Well, some one must "run it;" it cannot be otherwise. If the outsider does not like "so-and-so," let him join the society just the same. If he is right in his opinion, there will be many others to agree with him, and by their united efforts, they can vote all the undesirable "so-and-so's" to private life (medically speaking). Rings there will be; but with few exceptions the ring is an elastic body, which can take within itself any and all individuals with inclination and ability to work for the cause.

*Join your societies and work with the ring!*

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#### A NUISANCE IF NOT WORSE.

PHYSICIANS in the large cities and possibly elsewhere, have been, and are continuing to be, subjected to what may mildly be called a nuisance, if it is not an attempt at actual villainy. First, the victim receives some more or less extensive literature explaining how easy it is to gain a small fortune by investing a very small sum of money. In the course of a few days, the sender thereof calls the doctor up on the phone and supplements the pleadings of the circular with explanations over the phone, and possibly seeks an appointment for a personal interview. Concerning the standing of these gentry—they call themselves Bankers with a capital B—we know noth-



ing. We do know, however, that their manners are simply execrable. We do know that phone calls are emergency interruptions, and as such, physicians are forced to suspend any work they may have on hand to listen to the alleged banker and purveyor of stocks with millions in them. We do know that one physician who listened to their pleadings and yielded thereto, lost a large sum of money. Our advice to all is to refuse absolutely to carry on any conversation with these individuals. If they are not robbers of the physician's cash, they certainly are of his time. They place the sick who may be consulting him in an uncomfortable position, and in so doing are guilty of inhumanity. There is no law to do away with the evil; but if the alleged bankers are met with the reception they deserve, the practice will be discontinued forthwith.

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#### **BREAST FEEDING VS. BOTTLE FEEDING.**

BREAST feeding is referred to in the pamphlet issued by the government on this subject (Keep Well Series No. 9; issued by the Public Health Service) as the Baby's Right and the Mother's Privilege. Its advantages over bottle feeding are summed up as follows:

Of every 100 bottle-fed babies 25 die in the first year of life. Of every 100 breast-fed babies 6 die in the first year of life.

Beside the amazing effect upon the mortality rate of infants breast feeding has many other advantages over bottle feeding to commend it. It is certainly less trouble for a mother to nurse her babe than to prepare bottles of different formulae for it which requires great time and care if it is properly done. And unless artificial feeding is carefully, conscientiously and scientifically carried out it may not only give poor results but the results are also frequently disastrous.

Almost every mother who nurses her babe can look with pride upon the progress which the baby makes; its regular gain in weight and growth and its freedom from the many digestive and nutritional disturbances to which the bottle baby is subject. Her baby at four months will, as a rule, be larger, heavier and brighter than her neighbor's baby of five or six months of age which has been raised on the bottle, and at a later age contrast may be even more striking. Many mothers

enjoy better health than ever before while they are nursing their babe.

These facts are well known to the average woman and it is seldom necessary to resort to arguments in order to convince a mother that the best thing for her and for the baby is that she nurse the same. The accusation is often made that women try to evade their duty of nursing the baby and that they deliberately resort to artificial feeding when they are fully capable of nursing their baby. Our experience with many hundreds of mothers has convinced us that there is no truth whatsoever in this allegation. It is true, there are a few exceptions, but the great majority of mothers are not only anxious to nurse their infants, but make honest and painstaking efforts to do so. When they fail, it is not their own fault. Failure is usually a great disappointment to them.

At the mother's clinic conducted by the Hahnemann Hospital, every effort is made to assist the mothers who are honestly trying to nurse their babes. Often success or failure depends upon whether the mother is able to procure sufficient and suitable food. We must bear in mind that the nursing mother must get enough nourishment to feed both herself and the baby. Tea and coffee will not make milk; the proper diet for the mother, unfortunately, calls for expensive articles of diet, such as milk, butter, eggs and a certain amount of meat and fresh vegetables. Also the nursing mother must have sufficient rest; hard work is not compatible with nursing a baby. The economic side of the question is, therefore, a very important one.

The family physician is often at fault. We see cases right along where the mother was advised to wean her infant "because her milk did not agree with the baby." The baby spit it up, or had colic, or its stools were loose and contained curds. These are simple faults which can readily be corrected, better by not weaning the baby than by weaning it. Often weaning means jumping out of the frying-pan into the fire. The profession should take this matter more seriously to heart and not be guilty of such poor and unjustifiable practice.

C. S. R.

## GLEANINGS

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### MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

**INTRATRACHEAL INJECTIONS.**—Moore (*Laryngoscope*, Oct., 1919, page 608) considers this a very valuable method of treating tracheitis accompanied by cough and hawking in the morning. He uses menthol in liquid albolene. In asthmatics a 1% solution of camphor in petrolatum. In tuberculosis, 2% guaicol in petrolatum. He uses the indirect method of application.

**NASO-PHARYNGEAL CONDITIONS TENDING TO PROLONG MENINGOCOCCUS CARRIAGE.**—Babcock (*Laryngoscope*, Vol. xxix, No. 8). Failure to disinfect meningococcic carriers led the Rockefeller Staff to seek the cause. Ten men from the army and 27 from the navy were investigated. Twelve of these were treated at the Institute. These were all stubbornly resistant to treatment. Conclusions from the investigations showed that the meningococcus carriers showed a high incidence of abnormalities in the nose and pharynx, particularly the presence of adenoids, the folds and depressions of which make an ideal protection from disinfectants. Correction of diseases of the nose and throat was of considerable aid in eliminating the meningococcus from carriers.

**SUGAR TREATMENT OF TUBERCULOSIS.**—Sterling gives his experience in the treatment of pulmonary tuberculosis by the subcutaneous injections of sugar. While of course we cannot participate in his enthusiasm, we are forced to admit that the method he employs is harmless, and may aid other established lines of treatment in conjunction therewith. The idea is by no means a new one, as it has been practised by numerous physicians within the past 10 or more years. Sterling has used it in six cases, and the details of the progress of his cases are sufficiently encouraging to warrant this excerpt. The entire technique is a very simple matter. Ampoules of 5 grains of saccharose in 5 c. c. of distilled water are prepared. The injections are given intramuscularly, preferably in the gluteal region daily or on alternate days. The injections appear to have but little influence on the progress of the fever. Night sweats and expectoration cease almost immediately. The reduction in cough was not in proportion to the reduction in the expectoration; hence a dry and distressing cough might be present in the beginning, but it was more or less controlled later. There was a marked gain in weight and strength with an amelioration of the toxæmia and its depression.—*Medical Record*, December 6, 1919.

**TYPES OF TUBERCULOUS LESIONS FOUND AT AUTOPSY ON SOLDIERS.**—Lieutenant Downing of the U. S. Army has analyzed the character of lesions found at autopsy on 112 soldiers who died of tuberculosis. Of these autopsies 54 were performed on men from various camps in the United States and 58 on men returned from France. There was only one case of acute primary tuberculosis. The majority were of the chronic type, both in point of time



since first symptoms, and in the character and spread of the disease. Accidents in the course of the disease were fairly common; there were many cases of spontaneous pneumothorax among the cases from U. S. A. General Hospital, No. 16 (New Haven), and many terminal secondary infections among those from U. S. A. General Hospital, No. 21 (Denver). Healed lesions were found in 10 of the 16 non-tuberculous cases of the series. There was practically no difference between the types of lesions in those in overseas service and those in home service.—*American Review of Tuberculosis*, December, 1919, vol. III, No. 10.

LOBAR PNEUMONIA.—T. Stuart Hart, in an article which sums up a year's experience with 121 cases in the Presbyterian Hospital in New York, and the results with the use of the antipneumococcus serum, presents several interesting tabular records, discusses the different groups or types studied and treated, and concludes by stating that:

1. A positive blood culture in lobar pneumonia is usually an indication that one may expect a severe course.

2. It is rare for a patient who has just received serum to escape a subsequent "serum illness." This may be mild or severe, but bears no relationship to the amount of serum given. Serum illness in these cases does not endanger life.

3. Antipneumococcus serum is a distinct aid to nature's effort to sterilize the blood stream.

4. When serum fails to sterilize the blood, an acute pneumococcus endocarditis should be considered as a possible cause. This was present in three of our cases.—*Boston Medical and Surgical Journal*, Dec. 18, 1919.

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## PATHOLOGY

Conducted by Jno. G. WURTZ, M. D.

A METHOD FOR THE PRELIMINARY DETECTION OF ABNORMAL MILK BASED ON THE HYDROGEN ION CONCENTRATION.—Baker and Van Slyke (*Jour. Bio. Chem.*, December, 1919, p. 357) describe a method for the detection of abnormal milks. One drop of a water solution of brom-cresol purple is mixed with 3 mls of milk and the color observed. Normal fresh milk yields a grayish-blue color. Acids, formaldehyde and heating above the usual degree for pasteurization give a lighter color; while deeper blue is found in milk from diseased udders, watered milk, skimmed milk and milk containing alkaline salts. Standard colors can be compared to assist in the discovery of abnormal milk, which milk can then be taken to the laboratory for further study. The test is not a final one; but milks giving the normal color need no further examination. The test minimizes the work of milk inspection.

BOTULISM.—To determine the characteristics of *B. botulinus* is very timely, since the recent campaign to conserve food. Throughout the country isolated cases of botulism are found, with occasionally an outbreak in some special location. Dicksom, Burke and Ward (*Arch. Inter. Med.*, December, 1919, p. 581) have recently done much work along the line of the effect of various canning methods on the spores of the *B. botulinus* and the formation of its toxin. They found that the resistance of the organism is greater than usually supposed and that none of the usual canning methods are ideal when

the raw fruit or vegetables contain the spores of the bacillus. Weak acid solutions (lemon juice) render the spores less resistant to heat and boiling destroys the toxin. They point out that for various reasons the home canned foods are the most likely to harbor spores of the *B. botulinus*, and are especially dangerous if eaten without further cooking.

**TOXIN AND ANTITOXIN OF *BACILLUS DYSENTERIAE* SHIGA.**—Olitsky and Kligler (*Jour. Exp. Med.*, 1920, p. 19) have succeeded in isolating both an exotoxin and endotoxin from *B. Dysenteriae* Shiga. The existence of a toxin was long recognized and much work has been done along the lines of recovering it. However, the existence of two poisons was never satisfactorily demonstrated. These toxins have been recovered separately and experiments upon rabbits show that each has a selective affinity for certain tissues. One affecting the central nervous system and the other the intestine. A potent antidysenteric serum containing antibodies against both the exotoxin and endotoxin can be produced in horses, as the authors have experimentally demonstrated.

**THE RELATION OF GLYCOGEN TO THE PATHOLOGIC CHANGES IN PANCREATIC DIABETES.**—Ervin (*Jour. Lab. and Clin. Med.*, December, 1919, p. 146) recalls the view of Fischer, which is that fat in the tissue is held in the emulsified state by means of proteins; and that the power to emulsify fat is dependent upon the hydrophilic nature of the colloid (protein). Ervin expresses the view that glycogen is a hydrophilic colloid and has better emulsifying power than protein and is more resistant to acids, alkalies and salts. He experimented with various combinations of protein-fat, glycogen-fat and glycogen-protein-fat emulsions to prove this contention. Glycogen, he found, is a stabilizing agent in the emulsion and adds a strong element of resistance to acids. He believes that the acids formed through the action of poisons, hydrolize the glycogen (witnessed by hyperglycemia) then cause a separation of the protein-fat emulsion in the tissues. He believes in treating poisoning, as from mercury and chloroform, the patient should be alkalized and fed carbohydrates to prevent so-called fatty degeneration (breaking up of the emulsions in the tissues). Diseases producing a hyperglycemia frequently show after death a fatty degeneration of the tissues. Acetonuria, the author believes, is an indication of what is taking place in the liver and other tissues. He believes it is the sign of too great a load of fat being oxidized and not a failure in oxidation. Lipemia in diseases presenting hyperglycemia and acetonuria is given as further evidence of a breaking up of the glycogen-protein-fat emulsion, with the entrance of free fat into the blood stream. Ervin also expresses his view upon the staining of fats.

**ALKALINE RESERVE CAPACITY OF WHOLE BLOOD AND CARBOHYDRATE MOBILIZATION AS AFFECTED BY HEMORRHAGE.**—That a hyperglycemia frequently follows hemorrhage has been known for a number of years. Tatum (*Jour. Bio. Chem.*, January, 1920, p. 59) reminds us that so far no satisfactory explanation for this has been forthcoming. With the idea of throwing more light upon the subject, he experimented with laboratory animals along this line. His results lead him to believe that the hyperglycemia is due to a disturbed acid-base balance and that the liver plays a part along with other body cells. He found that coincident with the hyperglycemia there occurred a fall of the alkaline reserve of the blood and the increase of blood sugar,

which is manifested very soon after hemorrhage, was lessened in degree by the administration of appropriate doses of alkali. On the other hand, the administration of acids tended to increase the hyperglycemia. Injections of sugar into the blood, he found, did not produce a fall of the alkaline reserve, though as stated, after hemorrhage the reserve falls as the sugar content increases. Within a few hours the balance is regained and recovery from the disturbance ensues.

THE DETERMINATION OF BLOOD VOLUME BY THE CARBON MONOXIDE METHOD.—Salvesen (*Jour. Bio. Chem.*, November 1919 p. 109) calls attention to the confusion regarding the exact volume of blood in humans. Values ranging from 1-21 to 1-8 of the body weight are given. He reiterates several methods of blood volume estimation and used in his work with rabbits and humans, a combination method which brought him to the conclusion that in male rabbits the blood volume is 1-20.21 of the body weight; while in female rabbits it is 1-19.99. Seven determinations in six healthy men revealed the blood volume to be on an average of 1-16.8 of the body weight, or 5.95 cc. per 100 gm.

A STRAIN OF CONNECTIVE TISSUE SEVEN YEARS OLD.—Eberling (*Jour. Exp. Med.*, December 1919, p. 531) reports that a strain of connective tissue isolated from a fragment of heart from a chick embryo, by Dr. Carrel, on January 17, 1912, is still alive after undergoing 1,390 passages. He describes in detail the technic and care used in making subcultures and the method employed to determine the rate of growth.

PLACENTOMATA AND CHORIOMATA OF THE TESTICLE.—Hartmann and Peyton (*Bull. acad. de med.*, Par., 1919, lxxxi, 733) have studied fifty cases, in twenty-seven of which exact microscopic examinations were made. Fourteen of these twenty-seven were choriomata, and the remainder placentomata. Some of these tumors contained both kinds of cells, which merely represent two different stages of development in fetal tissue. The authors have personally seen and operated on one case of chorioma, and have seen two cases of placentoma, and have found forty other cases in medical literature. They think that the number of cases of chorioma reported will increase, because hitherto such cases have been reported under various other names, such as cystic tumor and Wolffian tumor. The authors, from their studies, arrive at the conclusion that there may be observed in the testicle a series of tumors corresponding to successive development stages of the ovum, the embryo and the fetus. In these tumors, there is a proliferation of trophoblasts, which are the cells that form a bond between the mother and the fetus; thus constituting either a placentoma or a chorioma.

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## DERMATOLOGY.

Conducted by RALPH BERNSTEIN, M. D.

ADENOMA SEBACEUM.—Five cases of adenoma sebaceum occurring in one family consisting of father and four children is reported by J. B. Shelmire. All of the members of the family were of more than average intelligence, whereas in many of the cases previously reported the patients were all of a low degree of mentality. The treatment given consisted of carbon dioxide snow entirely, and the results were excellent.—*Jour. Amer. Med. Asso.*



**COLLODION IN FACIAL ERYSIPELAS.**—At Camp Cody, Lieutenant Avata and Major Woodyatt revived the use of collodion in the treatment of erysipelas, which was first described by Niehans, and found it more satisfactory than any other method of treatment. Collodion U. S. P. (non-flexible) is painted on with a cotton swab or brush to form a stripe half an inch wide and an inch in advance of the line of induration in such a way that the diseased area is completely circumscribed. This stripe is painted over repeatedly until when dry it makes a deeply constricted furrow, unbroken and perfect at every point. On the following day the collodion line is inspected for breaks or cracks or inadequate constriction at any point. If such be found they are repaired by further coats of collodion. When enough collodion is used to produce a continuous and sufficiently deep linear constriction of the skin, the erysipelas induration advances to the collodion and no farther. The collodion is left in place until the temperature and swelling have well subsided. If there is a break in the collodion line, or if the skin constriction be too shallow, the disease may pass through or beyond it, and successful results depend upon the complete constriction of the lymphatics of the skin through which the infection travels. This method of treatment, compared with the results by other methods, indicates that it considerably shortens the length and the height of the fever course, lessens the toxic symptoms generally, and in facial erysipelas reduces the frequency of abscess formation almost to nothing, since these occur seldom where the erysipelas is confined to the face.

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#### PEDIATRICS

Conducted by C. SIGMUND RAUE, M.D.

**ACETONURIA AND CYCLIC VOMITING IN CHILDREN.**—Joseph Garland discusses the subject of Cyclic Vomiting in the *Archives of Pediatrics*, August, 1919. Children of a rheumatic or lithemic diathesis, especially if there is a distinct neurotic inheritance, are very prone to periodic attacks of fever accompanied by nausea and vomiting; loose, green, mucous, foul-smelling stools; anorexia and loss of weight. Acetone is present in the urine in large amounts and the breath has a strongly acetone odor. The physiological defect appears to be a poor fat and carbohydrate metabolism. The proper treatment for the attack itself is an alkaline one, consisting of the administration of milk of magnesia and bicarbonate of soda internally and of colonic irrigations with a solution of bicarbonate of soda. Between the attacks the diet should be low in fats and sugars and proper attention should be paid to the general routine of the child's life, with the aim of preventing any undue mental or physical stress.

**INFLUENZA IN CHILDREN.**—The subject of influenza in children is discussed by C. S. Raue (*Jour. Amer. Institute of Hom.*, Jan. 1920) in a symposium on influenza read at the 1919 session of the Institute. Attention is called to the fact that many valueless opinions were expressed concerning the epidemic of influenza which might have been left unsaid had their authors taken the trouble of reading the descriptions of past epidemics in the standard text-books of medicine.

The epidemic of 1918 resembled in most respects all previous epidemics although it presented some individual peculiarities. Thus, in the fall of 1918 when influenza broke out in this vicinity, children were not frequently attack-

ed. Later, however, during the winter, they began to fall victims to the disease just as adults had succumbed before them. As a class, they stood the disease better than the adults. A fair percentage however, unfortunately developed the pulmonary complications so characteristic of this past epidemic and succumbed to the same. There were perhaps a few cases of genuine lobar pneumonia which were diagnosed as influenza; an error which naturally occurs whenever any disease is epidemic to sufficient extent to overshadow for the time being any other acute disease.

The clinical course of influenza may be described briefly as being characterized by sudden onset after a surprisingly short period of incubation, with chilly sensations and aching; rapid rise of temperature, averaging 103 F. pulse variable, often characteristically slow; marked drowsiness and prostration. In the majority of cases the face was decidedly flushed and many cases presented marked infection of the conjunctivae. It is quite possible that in such the initial infection occurred in the conjunctival mucous membrane and was carried thence to the mucosa of the nose and pharynx. The clinical picture produced by this flu-hed appearance of the face, the infected conjunctivae, the drowsiness and prostration of the little patients was so characteristic that the disease could be recognized at a glance.

The temperature ran continuously high for three days in the majority of my cases, falling abruptly and then again rising after an afebrile period of from twelve to twenty-four hours, with the appearance of chest symptoms. The secondary rise may be delayed even longer and be interpreted as a relapse, rather than as the period of pulmonary localization of the disease. Cough, increase of fever, increased pulse rate and respiratory rate, the appearance of rales in the chest, dry and moist rales in the bronchi and subcrepitant rales at the bases, cyanosis, increasing prostration and circulatory failure and a pulmonary edema (inflammatory) are symptoms which develop in the unfavorable cases. Many cases fortunately go through the secondary febrile period with nothing worse than a distressing cough, increased prostration, anorexia or vomiting, the fever dropping by lysis at the end of four days, making a total febrile course of seven days from the time of onset in the average case with bronchial involvement.

Strumpel in his Text-book of Medicine calls attention to this characteristic fever curve which he designates the "double-pointed curve" and rightly attributes the second rise to the onset of bronchopneumonic manifestations. This relapse occurred so regularly in my little patients that I made it a rule never to allow a child to get out of bed until the morning and evening temperature had been normal for at least three days, no matter how mild the attack of influenza had been. Some escaped the bronchial stage of the disease and the fever only lasted three days in such cases.

A most important clinical manifestation during the initial period of the disease was a well-marked leucopenia. A white blood-cell count of two to four thousand was found in practically all cases at this time. Later on, especially in the cases with well developed bronchopneumonia, a leucocytosis was usually present, due most likely to a secondary infection with the streptococcus.

Bronchopneumonia was the most frequent complication and accounted for the majority of the fatalities. Myocarditis with acute dilatation of the heart was occasionally encountered. Empyema was not a common complication; in one of my cases it developed during the second week and a hemolytic

streptococcus was isolated from the pleural exudate. Bloody tinged fluid in the pleural cavity was a common finding at autopsy but fibrin was usually absent.

The bronchopneumonia was characterized by intense congestion of the mucosa of the bronchial tubes and of the pulmonary parenchyma. Hemorrhagic areas were found throughout the lungs and an asphyxiative bronchiolitis was frequently found in the fatal cases in young children. Christian, in his observations made on the cases of epidemic influenza under his care at the Peter Bent Brigham Hospital, found that in every fatal case there were invariably physical signs justifying an antemortem diagnosis of bronchopneumonia.

The symptoms indicating the onset of bronchopneumonia were increased respiratory rate, cough, scattered coarse rales, both dry and moist in the larger bronchi and subcrepitant rales at one or both bases.

In many cases the earliest evidence of pulmonary consolidation which could be detected was dulness and subcrepitant rales heard at the angle of a scapula. In unfavorable cases the consolidation spread rapidly to the bases, the physical signs simulating those of a lobar rather than of a bronchopneumonia, although there was usually bilateral involvement, however, not equal. During the terminal stage of the disease, cyanosis was marked and moist rales could be heard over the entire chest, in front as well as posteriorly and in the upper part of the chest as well as at the bases.

In the *treatment* of influenza, the indicated homeopathic remedy proved itself far superior to any specific or physiological treatment. Nursing of course was most important. The support of the patient's strength by careful feeding, hydrotherapy, fresh air and tactful nursing was imperative. During the first period of the disease, in the absence of serious bronchial symptoms, stimulation was unnecessary; but with the onset of the marked toxemia and prostration which characterized the bronchial type of the disease, proper doses of alcohol were decidedly beneficial. Heart failure called for camphor in oil and caffeine; the latter I found superior to camphor.

Aconite, belladonna, and ferrum phos. were more frequently indicated in the early stages of my cases than any other remedies. I found aconite decidedly superior to gelsemium. Ferrum phos. was indicated for the early stage of the bronchitis; the hoarse cough with the blood-streaked expectoration which was so common, almost justified its routine use in alternation with aconite or belladonna according to which one of the former was best indicated. Bryonia was also frequently indicated in the early stages in alternation with aconite or belladonna. For the pneumonic manifestations, phosphorus, scilla maritima and tartar emetic, were most frequently useful in my experience.

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## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY

Conducted by JOS. V. F. CLAY, M.D.

LOCAL ANAESTHESIA AND THE MASTOID OPERATION.—Goldstein (*Laryngoscope*, Vol. xxix, No. 10). During the recent epidemic of influenza the frequency of active respiratory inflammation prevented the risk of operating under protracted general anaesthesia. This report covers a series of twenty cases of acute mastoiditis successfully performed under local anaesthesia. The principle under which this anaesthesia is based is that of constant pressure on nerve distribution in the skin and secular tissues. The technique: Novo-



caine,  $\frac{1}{2}$  of 1% with equal parts of adrenalin chloride 1—10,000 boiled. First, subcutaneous injection beginning with the mastoid area in the zygomatic line and working toward the tip. The infiltration includes a belt about one inch in width and extending from the line of auricle backward and parallel to it. The deep injections follow same area at four points, the needle being worked between the periosteum and bone by a slight rotary motion. The usual incision is made. Before elevating the periosteum a cotton pledget saturated with 10% cocaine solution is placed in the wound for four or five minutes. The difficult area to anaesthetize is the posterior wall of the external auditory canal and middle ear cavity. A long injecting needle is passed to the depth of the mastoid incision just between the periosteum and bone and carried to the fundus of the canal as far as possible. Two or three c. c. of solution are delivered at this point.

The writer gives brief notes of the twenty cases and is quite satisfied with the completeness of the anaesthesia as evidenced by the conduct of the patient during operation.—*Journ. Amer. Med. Asso.*, Vol. 73, No. 9.

**RADIUM THERAPY IN TUBAL STENOSIS.**—Holmgren (*Laryngoscope*, Vol. xxix, No. 10). Three cases are reported, one presenting symptoms of tubal stenosis due to sarcoma just behind the orifice of the tube. The aural symptoms disappeared after the first application. The second case was probably also a malignant condition of the naso-pharynx. The aural symptoms entirely subsided after two applications. The patient was, however, treated again six and nine months later; each time he was free of symptoms. The third case was a clear cut case of tubal catarrh. In this case a radium tube was placed in the mouth of the tube. It is claimed that the action of radium upon lymphoid tissue was the reason for the prompt subsidence of the tubal symptoms.

**PRESENT STATUS OF TEACHING THE DEAF.**—Goldstein (*Laryngoscope* Sept., 1919). Teachers of the deaf and defective speech have been called upon for an important contribution in the rehabilitation and re-education of the injured soldier. Shell shock and shell concussion caused numerous cases of deafness. Explosion and close range fighting with subsequent mutilation of lips, cheeks, mouth, nose, jaws and neck, require, after convalescence, re-educational measures by which the functions of speech, hearing and sight could be readjusted or rehabilitated. Lip reading and corrective speech was conducted at U. S. A. General Hospital at Cape May.

Wright would have impaired hearing a reportable condition, believing by such legal measures it would be possible to safeguard the interests of the deaf child and to keep in touch with his educational opportunities. Active efforts are being put forward to standardize educational methods, as applied to the deaf child. The general acceptance of oralism depends upon high grade oral teachers. Oralism must succeed over manualism by practical evidence of accomplishment.

**ACCESSORY NASAL SINUSES OF CHILDREN.**—Oppenheim (*Journal A. M. A.* Vol. 73 August, 1919.) The writer believes that many cases of meningitis are the result of unrecognized inflammation of some of the sinuses, as the symptoms of sinusitis in children are more or less obscure. Chronic sinusitis in children is common and frequently the cause of a post-nasal catarrh. The ethmoidal cells and antrums are more frequently involved. The ethmoid

develops into distinct cells about the fourth year and from that period on are susceptible to morbid changes. Previous to the seventh or eighth year the frontal sinus is usually not developed, although not infrequently it is present as early as the fifth year. The sphenoid shows a definite cavity as early as the third year; by the seventh year it is well developed. Its lateral walls are well within the intracranial cavity, this being of importance in the development of obscure cases of basal meningitis. It is in relation with the internal carotid artery and cavernous sinus laterally and superiorly.

The recognition of sinus disease in children is difficult as symptoms are usually obscure. Influenza, scarlet fever, measles and pneumonia are activating factors. In the new born, antral sinusitis may occur as a consequence of infection by vaginal discharges or from injury in instrumental delivery. Bacteriologically the staphylococci are found in equal if not greater frequency than other organisms. This is in all probability not the primary infecting organism but secondary invaders.

In the diagnosis, the Roentgenographic plates are of great service. Frequent headache should occasion suspicion of sinus trouble especially if parts are tender. Cessation of pain with the appearance of free nasal discharge and return of pain when discharge lessens is observed in sinus disease. Adenoids are not always the sole source of a continued coryza but in addition there may be a sinusitis. Aprosopia and disturbances in general health are symptoms concomitant of chronic purulent sinusitis. In so called strumous children presenting purulent nasal discharge, excoriated upper lip, marginal blephoritis and frequently corneal ulcers, purulent sinusitis, usually of the antrum and ethmoid cells, exist. In the acute fulminating type serious orbital complications may occur, thrombosis of the cavernous sinus, pyemia, meningitis and death. In milder cases, oedema of the eyelids is a valuable symptom. Purulent infection of the sphenoid is exceedingly difficult and practically always combined with ethmoidal changes. Occipital or vertical headache with dizziness is suggestive. Discharge is scanty and becomes inspissated in the naso-pharynx about the posterior portion of the vomer and floor of the choanae. The treatment should aim to destroy as little tissue as consistent with attaining permanent results. Palliation treatment will cure the majority of acute cases. Warm alkaline sprays and weak epinephrin solution, rest in bed and general measures as indicated. Some form of suction for freeing the nose and ostii of secretion proves beneficial. In operative treatment strong emphasis is laid upon preserving turbinal tissue. Drainage should be accomplished as far as possible through the natural openings, removing such osseous tissue as necessary. External operation is to be thought of only in certain fulminating cases and in persistent suppurating cases.

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## UROLOGY

Conducted by LEON T. ASHCRAFT, M.D.

PUNCTURE FOLLOWED BY INJECTIONS OF VAN SWIETEN'S FLUID COMBINED WITH EXTERNAL MASSAGE FOR THE RADICAL CURE OF VAGINAL HYDROCELE.—Guiard (*Jour. d'Urol. med. et Chir.*, 1919, VIII, 53) considers the above a simple method of treatment, and one within the ability of all practitioners. No severe or prolonged inflammatory reaction is produced by this fluid, as is the case after injections of iodine. The author employs a No. 9 Charriere trocar, the serosa being then anesthetized with cocaine, and the

20 c. c. of Van Swieten fluid injected. The reaction is usually insignificant. While the fluid is being retained for a few minutes the testicle is massaged. This procedure is repeated several times. Prostatic abscess, suppurative Bartholinitis and ganglion abscesses are treated in a similar manner.

DIAGNOSIS AND TREATMENT OF UNILATERAL RENAL TUBERCULOSIS.—Herman (*Annals of Surg.*, 1919, LXX, 203) states that tuberculosis of the urinary tract usually affects the kidney first. It may be localized in one kidney for a considerable period of time, without invading other structures. Finally, however, it spreads along the course of the ureter and involves the bladder, from there extending up to the other kidney. If nephrectomy is performed before the bacilli have invaded the bladder, the prognosis is much better than it is after extension has occurred. The author refers to 64 cases complicated by involvement of the bladder, in which but 19 remained well after nephrectomy; whereas there were one hundred per cent. of cures by this operation in 34 cases in which the disease was limited to the kidney. Usually it is not necessary to remove the ureter. With certain exceptions, it should either not be disturbed at all, or only that part that can be conveniently reached through the nephrectomy wound removed. These exceptions are: (1) cases in which the ureter is strictured below, dilated above and secondarily infected; (2) those in which the ureter is dilated, infected and in free communication with the bladder cavity; and (3) those in which the ureter is enlarged, soft and diffusely involved by subacute miliary tuberculosis. Numerous infections in the kidney and epididymis, of course, render the prognosis more unfavorable.

THE EARLIEST EVIDENCE AND THE LAST TRACE OF SYPHILITIC INFECTION.—Paul (*Urol. and Cut. Review*, Nov., 1919) believes that the Wassermann test shows evidence of an attempt at immunization against syphilis, rather than the presence of the infecting agent, and considers it comparable to resistance to reinoculation with syphilis. It does not become positive until some time after the appearance of the chancre. He thinks that the *Treponema pallidum* and the Wassermann reaction will become obsolete means of diagnosis as soon as some one discovers a way to demonstrate resistance to syphilis causing reinfection. Experimental inoculation performed for diagnostic purposes in a case in which recent infection was suspected would be worthless, because the patient would acquire syphilis anyhow—if not from the sexual partner, then from the diagnostic test.

ACUTE RETENTION OF URINE.—Harrison (*Urol. and Cut. Rev.*, Nov., 1919) calls attention to the fact that treatment should first be directed to relieving the retention, and secondly to removing the underlying cause. In arriving at a diagnosis as to the etiology, the history plays an important part. Acute retention may develop upon chronic retention. The patient should be closely questioned, in order to learn if any irritating injections have been used or any traumatism has been sustained. A careful examination should be made for the presence of a fluctuating tumor. Strict aseptic precautions should be maintained in trying to pass any instrument into the bladder. He warns of the danger of using even one per cent. cocaine as an anesthetic in this condition, preferring four per cent. novocaine. In the event of failure to pass a catheter of any kind, external urethrotomy should be performed, either with or without a guide. Cases in which there is no obstruction in



the urinary tract must be studied from the neurological side with regard to reflexes, Wassermann reaction and examination of the spinal fluid. The author reports a case in which the condition was probably due to atony of the bladder caused by anterior sclerosis. During a course of treatment with increasing doses of strychnine by mouth, the residual urine decreased and finally, at the end of a month, he was able to empty the bladder completely. He remained well for two years and a half. Then he had a similar attack, with the same course of events. After a month of the same treatment, he left the hospital. It has been a year since then, and he is still perfectly well.

THE FREQUENCY AND SIGNIFICANCE OF GRANULAR URETHRITIS.—Aronstam (*Urol. and Cut. Rev.*, Nov., 1919) thinks that the frequency of this condition has been underestimated, owing to the fact that every case of urethritis has not been examined urethroscopically. He considers every case of granular urethritis chronic. Among 150 cases of chronic urethritis taken at random from his records, he found 76 cases to be granular. In 46, the lesion was in the posterior urethra; and 20, in the anterior. Sixty-nine of the 76 were gonococcal in origin. Stricture of the bulb was the most common complication, with recurrent epididymitis as second in importance, while prostatitis and spermatoecystitis ranked as third factors. The author ascribes etiological importance to these complications, stating that they constitute a vicious circle in prolonging the disease, acting as cause and effect. Aronstam quotes his own previous articles as to the symptomatology and treatment of the condition, so it is not necessary to consider them here.

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## SURGERY

Conducted by J. DEAN ELLIOTT, M.D.

AMPUTATION ABOVE THE LEVEL OF ARTERIAL OBSTRUCTION IN ARTERIO-SCLEROTIC GANGRENE.—Eisendrath and Bettman state that the amount of gangrene is a poor guide for the choice of an amputation site, as not infrequently amputation is followed by extensive sloughing of the flaps, or, as in a case recently observed by them, extension of the thrombosis from the affected femoral artery to the opposite iliac. The authors believe that the ideal method of choosing the level at which to amputate would be exposure of the femoral artery at the middle of the thigh and to follow it in an upward or downward direction until a level was reached at which the thrombotic occlusion of the artery ceased, and distinct pulsation could be observed in the vessel. They recite a recent case in which pulsation was found only just below Poupart's ligament and amputation, even at this level, was followed by moderate gangrene of the skin flaps. Although the patient had been extremely septic the recovery was uneventful.—*Journal of the A. M. A.*, December 6, 1919.

THE PARAFFIN-WAX TREATMENT OF BURNS, WITH SPECIAL REFERENCE TO MUSTARD-GAS BURNS.—Taylor presents his experience with burns in general, and those from mustard-gas in particular, at Base Hospital No. 64, A. E. F. A summary of his findings are: All burns are sterile at the time of their receipt; all burns are infected clinically and bacteriologically at least twelve hours after their receipt; the Carrel method of handling burns is superior to any other; the paraffin-wax treatment has proven its worth in

every particular, both regarding the surgeon and also the patient, for time of disability is shortened, suffering is lessened, deformities and frightful cicatrices are prevented and the results are wholly worthy of the energy expended.

*Steps of the dressing.* (1) Removal of dressing. (2) Wound cleansed with sterile absorbent cotton dipped in neutral soap and peripheral skin thoroughly scrubbed with same soap. (3) Removal of soap with warm sterile water and sterile cotton pledgets. This cleansing process is one of the most important steps in the technique. There should not be any bleeding, pain or distress, and if there is any of these, the technique is not being carried out properly. Oftentimes the secretions are more easily removed by substituting normal salt solution for the sterile water. (4) Thorough drying of the area, either with sterile cotton pledgets or by means of a blower. The area must be dry before the application of the paraffin. (5) Apply the paraffin-wax preparation over the burned area and at least a quarter inch of the peripheral skin. (6) Over this place immediately as thin a layer of sterile absorbent cotton as can be obtained from the cotton roll. These layers should have been previously prepared and sterilized. (7) On this film of cotton is placed a second layer of wax likewise extending beyond the edge of the wound. (8) Over this apply a thick layer of absorbent cotton. (9) Then apply gauze and a bandage. (10) Redress every twenty-four to forty-eight hours, depending on amount of the secretion. (11) Only touch wound with sterile cotton pledgets. Keep fingers off and out.—*The Military Surgeon*, January, 1920.

**THE DEEPER STRUCTURAL CHANGES ARISING FROM VARICOSE ULCERATION.**—Morris states that diffuse periostitis and osteomyelitis of both bones of the leg, chronic in character, develop with varicose ulcers. Accompanying these are widespread vascular changes, the deeper vessels, posterior tibial and peroneal, show marked calcification. The sclerosis occurs independently of the site, depth and size of the ulcer, but is greatest when it has been present over a long period. The article contains a number of X-rays illustrations which show the condition of the bones and arteries. The bony disease is probably caused by infection through the blood supply, the arteries becoming diseased secondarily to the lymphatics draining the ulcer.

The author raises the interesting question as to injury of deeper structures and believes further study may prove that the kidneys, heart and nervous system may be seriously affected by such cryptic infections. Prompt recognition and vigorous eradication of such lesions would then be regarded as essential to the prolongation of life.—*Surgery, Gynecology and Obstetrics*, January, 1920.

**GALLBLADDER DISEASE.**—Branon has summarized the results obtained on 425 patients admitted to the Hartford Hospital from 1914 to 1918, in whom a gallbladder or gallduct disease was suspected or found during treatment. A personal letter was sent to 350 patients who left the hospital, of whom 148 filled in and returned the questionnaire. Each staff surgeon's work is represented; also a liberal sprinkling of private work done by non-members of the hospital staff.

In studying the report it will be noted that when patients with gallbladder disease pass the 50-year mark, the operative mortality rises very abruptly, as out of seventy-one patients admitted between 50 and 60 years,

thirteen, or  $18\frac{1}{3}$  per cent. died. Of thirty-eight between sixty and seventy, seven, or  $68\frac{1}{3}$  per cent. died, while out of two hundred and seventy-eight under 50, five, or 1.8 per cent. died. As the vast majority of cases develop before 50 years the eventualities should be prognosticated and early operative procedures undertaken. Of previous diseases, constipation is the most striking and of undoubted significance.

The addition to the twenty-nine previous appendectomies of the thirty-nine chronically inflamed appendixes removed at the time of gallbladder operation makes a total of sixty-eight; a rather large coincidence.

Of the acute infectious diseases in this series of cases, typhoid fever was not noted as frequently as recurrent attacks of tonsilitis, and only slightly more frequently than was scarlet fever, pneumonia or rheumatism.

When the eighty-three males are added to the twenty-three unmarried females and the one hundred and sixty-eight married women who did not give a history of child-bearing, there is a total of two hundred and seventy-four cases occurring independently of child-birth; and when it is recalled that the age of gallbladder disease coincides pretty closely with that of gestation, it does not seem that the latter is of unusual significance.

Indigestion without typical gallbladder pain was one of the most difficult symptoms to solve, and delayed the accurate diagnosis for a long time in many cases.

The comparative results of cholecystotomy and cholecystectomy in this series of cases show 44 unsuccessful drainages against 5 unsuccessful removals.—*Journal of the A. M. A.*, January 17, 1920.

**MODERN TREATMENT OF THE WEAK FOOT.**—In the army, orthopedic surgery was able to accomplish a great deal more in this condition than it often has been able to do in civil life, largely on account of rigid discipline and the desire, both of the patient and physician, to make a man fit to do his whole duty. On account of this success a number of surgeons who were specially trained along orthopedic lines and saw only the results obtained in cantonments in this country and base hospitals abroad may be too optimistic. It is for this reason that Whitman chose this subject for his paper.

At present there are two schools of treatment of weak foot, the first believes that the interest of the patient in his feet ends when he can be relieved of pain by appliances, such as foot plates, and to attempt to overcome life-long habits of gait, style of shoes, etc., is a waste of breath. On the other hand army experience demonstrated that the great majority of foot troubles can be cured without any apparatus whatever.

In civil life a different class of patients are met; they are older, have fixed occupations, are not so interested in a cure and usually expect to be given a shoe that will give immediate relief.

Except in rare instances of congenital flatfoot, the weak foot is caused by the persistent attitude of eversion and to overcome this in civil practice a brace that will support the arch and provide lateral pressure must be used for a time at least. Careful and accurate fitting and adjustment are necessary to make the apparatus comfortable and accomplish its purpose and this matter should never be left to the vagaries of the brace maker, but must be supervised by the physician. After the application of this support, it must be made clear to the patient that the ultimate outcome depends entirely upon himself. If proper exercises are diligently carried out and incorrect habits overcome, the brace can gradually be discarded and a complete cure obtained in the large majority of cases.—*Journal of the A. M. A.*, Jan. 17, 1920.



# THE HAHNEMANNIAN MONTHLY.

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MARCH, 1920

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## Minutes of the Fifty-Sixth Annual Session of the Homœopathic Medical Society of the State of Pennsylvania

Chamber of Commerce Rooms—September 16, 17 and 18.

FIRST SESSION.—Tuesday morning, September 16, 1919.

The meeting was called to order by the President, Dr. Harry S. Weaver, of Philadelphia, at 10.30 A. M.

The Invocation was delivered by Rev. Edward J. Bond, of Philadelphia.

The Address of Welcome was delivered by Mr. George W. B. Hicks, representing the Chamber of Commerce.

The Response was made by Dr. Gilbert J. Palen, of Philadelphia.

The next order of business was the Adoption of the Program. A motion was carried that it be adopted.

On motion, the President's Address was postponed for half an hour.

In regard to the report of the Secretary, Dr. I. D. Metzger, Pittsburgh, stated that the report consisted of the minutes of the Pittsburgh meeting. He had the minutes recorded in the book, as was required by the Society, and was willing to read them, if the Society desired to hear them.

Dr. Palen made a motion that the reading of the minutes be indefinitely postponed. The motion was seconded and carried.

The Report of the Treasurer, Dr. Ella Goff, of Pittsburgh, was then read and showed a balance of \$2,362.66 as compared with \$2,088.48 in 1918.

On motion, duly seconded, the report was referred to the Board of Auditors for approval.

The following were appointed by the President as auditors: Drs. J. W. Stitzel, Hollidaysburg; William M. Hillegas, Philadelphia, and Irwin B. Gilbert, Philadelphia.

The Report of the Board of Trustees was read by Dr. G. Morris Golden, Philadelphia, and was as follows:

During the past year four meetings have been held, as follows: November 20, 1918; January 15, June 11, and September 1, 1919, respectively. Your officers, Board of Trustees, and various committees have been active and have done a great deal of diligent hard work for the success of this meeting. Through the invitation and courtesy of the Chamber of Commerce, of Philadelphia, we are allowed the privileges of this spacious and well appointed room for our meetings, and extend to them our thanks.

During the past year there have been a number of important subjects brought to our attention for consideration. I will outline these briefly.

A Committee on Industrial Health Insurance was appointed, to confer with the proper authorities on this subject; also a committee on HAHNEMANNIAN MONTHLY, to report from time to time, with recommendations in reference to the welfare and management of the Journal.

A friendly suggestion was made: That each county appoint one or two members to act as a legislative committee to co-operate with a central committee in the detection, securing of evidence against those persons engaged in the illegal practice of medicine; and notably those practicing without a proper State license.

The subject of Federation of State Societies has been under advisement and discussion. Communications from the Institute headquarters as regards its objects and results are very vague, doubtful and indefinite. Therefore, your Board has recommended that the Homœopathic Medical Society of the State of Pennsylvania defer the subject of Federation for another year. They are led to this action because of the lack of information emanating from Institute headquarters. Further suggestions in relation to two committees, namely those of Membership and Legislation. The Board recommended for your consideration that they be made permanent

committees over a period of five years, so that it may facilitate better work in their respective fields.

By the action of the Board of Trustees, the HAHNEMANNIAN MONTHLY has been published under the Board of Trustees of your Society, beginning with January, 1919. The suggestion is further put forth at this time that the Homœopathic Medical Society of the State of Pennsylvania take legal control of the HAHNEMANNIAN MONTHLY.

We trust that the present meeting will prove a benefit to all from scientific, as well as the social standpoint.

(Signed) G. MORRIS GOLDEN,  
*Sect'y. Board of Trustees.*

September 16, 1918.

It was moved and seconded that the report be accepted and spread on the minutes. Carried.

The Report of the Committee on Registration and Statistics was presented by Dr. I. D. Metzger, of Pittsburgh, the Chairman, as follows:

DR. METZGER: As Chairman ex-officio of this Committee, the Secretary is supposed to keep records of the various homœopathic organizations of the State, and especially of the institutions of the State. I have records of the medical societies of Pennsylvania, and also of the hospitals of Pennsylvania. These are on file and are transferred from one secretary to another, as elected. I have no record of any other statistics, and know of no others that should be kept. If there are any suggestions along that line, I should be glad to have them. I might amplify our records by having other records kept. I have the names of the societies and hospitals; and if it is your desire I shall be glad to read them. They give the name, the time organized, the secretary, the annual dues, the time of meeting, and the place of meeting. Is it your pleasure to have all these read, Mr. President?

On motion of Dr. Bartlett the reading of these was dispensed with.

The Report of the Committee on Legislation was, on motion of Dr. Bartlett, postponed until Dr. Krusen's arrival.

The Report of the Committee on Membership was presented by Dr. Clarence Bartlett, of Philadelphia, the Chairman, as follows:

REPORT OF COMMITTEE ON MEMBERSHIP: Your committee has done considerable work. I cannot tell you the



exact number of new members at the present time, but I have had typewritten, ready for the Board of Censors, the names of ninety-four men. If it is your pleasure to have me read the names of the college, the date of graduation, and the members who endorsed the application of these men, I will do so, but I would like to make a motion that the reading be dispensed with, and the applications be handed to the Board of Censors to be passed on.

Dr. Palen said he thought the names should be read.

Dr. Bartlett read the names of the applicants. (See page 161).

DR. BARTLETT: In addition to this I might remark that the faculty of Hahnemann has one hundred and five teachers; and that of these, all are members or have sent applications in, with the exception of one man, who is in the United States Navy Service, and could not be reached. Therefore, Dr. Weaver signed his application and paid the first year's dues. Therefore, we have one hundred and five teachers in Hahnemann, and one hundred and five are members in the Society.

Another organization is the Germantown Medical Society, with a hundred and sixty-two members, only four of whom are not members of the State Society. I think that these are two pretty good records.

DR. METZGER: I wish to state that the last name in the Beaver County Medical Society not on the membership list of the State Society was presented too late to be acted on last year, but that Dr. Raymer presented the name of Dr. Coss and paid his dues, so that the Beaver County Medical Society should have one hundred per cent. representation in the State Society.

On motion, duly seconded, the report was accepted.

The Report of the Entertainment Committee was presented by Dr. W. A. Pearson, of Philadelphia, as follows:

REPORT OF THE ENTERTAINMENT COMMITTEE: DR. PEARSON: Dr. Hunsicker asked me to make the report because he has a bad cold and does not know a good doctor to put him in proper shape. The entertainment program is printed briefly on the programme. I will call attention especially to the entertainment for the ladies. A committee of six has been appointed with Mrs. Warren C. Mercer as Chairman. This afternoon there will be a trip to Valley Forge; and tonight a theatre party at Keith's. Tomorrow there will be a lawn party, the start for which will be made from the

Adelphia Hotel at 12 o'clock. Transportation will also be furnished for the trip this afternoon and tomorrow. Printed programs for the ladies, I hope, will be distributed in the very near future.

Regarding entertainment features for the Society in general, let me call attention first to the banquet Wednesday evening, which we hope will be a success. The smoker tonight is primarily for men. There will also be clinics Thursday afternoon at Hahnemann Medical College Hospital. A printed schedule will be furnished; and also through the courtesy of Dr. Wilmer Krusen, Director of the Department of Public Health of Philadelphia, I am authorized by him to state that members of the Society wishing to visit any of the City Institutions, particularly the Hospital for Contagious Diseases, the Municipal Hospital and the Philadelphia General Hospital, or any other institution, will be most welcome. If they will give me their names, telling me what institution they would like to visit, I will see that they are properly taken care of with a permit signed by Dr. Krusen, and are shown every courtesy in any city institution that they may care to visit.

It was moved and seconded that the Report of the Entertainment Committee be accepted. Carried.

The Report of the Committee on Publicity was made by Dr. Ralph Bernstein, of Philadelphia, the Chairman, as follows:

DR. BERNSTEIN: Publicity is going on as usual, in the same good old fashioned way. During the past year, we had a great war on our hands, and a good deal of space was taken up with war news; and at this time there is a political campaign taking up space in the papers. Last year I could not go to Pittsburgh because of going to Plattsburg, but Mr. Wilson, who could not go, sent a very able representative and the publicity was good. We are having him again.

On motion, the report was accepted.

The Report of the Committee on Exhibits, by Dr. G. Morris Golden, Chairman, Philadelphia.

DR. GOLDEN: For the past several years the subject of exhibits has been a hard one to handle, due partly to war conditions. Nevertheless, we, Dr. Hillegas and myself, have done considerable work, and have put before you an exhibit of varying types of interest to everyone from various standpoints. All I can say is that I ask that you look at their ex-

hibits and listen to what they have to say. I think it will be of value to everyone. On motion this report was accepted.

The Report of the Committee on Homœopathy was deferred.

The Report of Delegates to the American Institute of Homœopathy was called for by the President, but no delegates were present.

The Report of the Woman's Homœopathic League was deferred.

The Report of the Committee on Congress of States and Election of Representatives was carried by Dr. W. A. Pearson, at the suggestion of Dr. Metzger.

DR. PEARSON: The original idea was presented by Dr. Scott Parsons and carried through at a meeting of the American Institute of Homœopathy. We are entitled to a certain number of representatives, and I presume that the idea is for the Society to instruct its representatives for the next meeting of the Institute.

DR. I. D. METZGER, Pittsburgh: I think that we should elect these representatives. Our Society, I understand, is entitled to a certain number; but if you please we will postpone that until later.

DR. CLARENCE BARTLETT, Philadelphia: Would it be improper to elect representatives, when we have decided that, in view of the indefiniteness of the information from headquarters, we postpone action on Federation? We do not think that we should appoint delegates.

DR. GILBERT J. PALEN, Philadelphia: Is there not a difference between a delegate to the American Institute and a representative to the Congress of State? They are under two separate headings.

DR. WEAVER: Yes.

No definite action was taken.

REPORT OF THE NECROLOGIST, DR. G. HARLAN WELLS, Philadelphia: Unfortunately, gentlemen, we have lost some valuable members of the Society during the past year. We hardly have the time to read a eulogy on these men and attempt to describe their valuable work for the Society and Homœopathy, but I can only say that we have lost one man whom, probably, we shall never be able to replace, Dr. B. F. Books, of Altoona. Among the following others are names so familiar to us that further comment is unnecessary:



Dr. M. D. Youngman, '11, Ardmore, Pa.

Dr. T. L. Bradford, '69, Philadelphia, Pa.

Dr. William Corson, Jr., '09, Collegeville, Pa.

Dr. Lewis B. Griffith, '80, Philadelphia, Pa.

Dr. Morris Hughes, '84, Kennett Square, Pa.

Dr. J. D. Keifer, '90, Mt. Carmel, Pa.

Dr. Robert Murdock, '13, Wilkes-Barre, Pa.

Dr. John W. Pratt, '73, Coatesville, Pa.

Dr. William B. Van Lennep, '80, Philadelphia, Pa.

DR. WELLS: Dr. Murdock was killed in France, and so far as I know, the only homœopathic physician of Pennsylvania, who was actually killed in the war. Some have died in hospitals but were not actually killed.

DR. ELLA GOFF, Pittsburgh: Dr. Martin died in France.

DR. WELLS: He died in England, in a hospital, but that was prior to the 1918 report.

On motion the report was accepted.

The Report of the Superintendent of the Allentown State Homœopathic Hospital was postponed.

There were no reports of local societies through their representatives.

The Second Vice-President, Dr. Stitzel, Hollidaysburg, took the chair, while Dr. Weaver read the President's Address. (Published in the *HAHNEMANNIAN MONTHLY*, October, 1919.)

Dr. Stitzel appointed as a Committee on the President's Address, Drs. G. Harlan Wells, D. B. James and Frank Nagle, all of Philadelphia.

Report of the Committee on Homœopathy was given at length by Dr. Aug. Korndoerfer, Philadelphia, Chairman, as follows:

I do not like to begin my remarks by making an apology, but I did not know that I was the chairman of such a committee. I had not been so notified. But there is so much going on in homœopathy at all times that it does not seem to be a matter that we should feel any hesitancy about making a general report concerning it. Therefore, I will make a brief verbal report of homœopathy during the past year.

The Homœopathic School has shown itself competent to take hold of anything that the Government asked its people to do. Our men have proved themselves good surgeons and good prescribers. Our results have been most successful. I

carried my little case with me, and got a good many doses from it. In that way I found it of great use. A good many men in the service should have compelled the Government to furnish homœopathic drugs to homœopathic physicians and surgeons, but this was not done. Many took enough interest to supply themselves with pocket cases containing enough drugs to see them through. They generally managed to have a sufficient amount, but it was at their own expense; and the results, so far as I can learn, of our work in the army and navy were extremely satisfactory. We, as a school, and our men deserve the recognition of our profession for the good work done.

During the epidemic of influenza last fall, all through this country, I may say, our school proved itself to be more than successful as compared with any other school of medicine. The mortality rate was extremely low.

The members of our Society are doing good work. The County Society of Philadelphia has been working faithfully along the lines of homœopathy. Our colleges have been doing good work, when we consider the condition in which our school was two years or three years ago, when we thought that the New York College would be compelled to close its doors. We find today that the need has been met, and that provision has been made to improve the situation; and I have been recently informed that the school is on an established basis again, from which we can hope great things. The Hahnemann College, which was sorely pressed by reason of a dearth of students and the extreme requirements referred to by the President in his address, was also in need of considerable assistance. The profession has come to its aid, however. The enthusiasm of our State Society and our alumni throughout the country has been such that the college is on a stronger basis than ever before; and it simply requires that the Alumni Association and the members of this Society should keep to their work and further the interests of our college; because it is only through our college that we can hope that homœopathy will be developed sufficiently to meet the demands of the country.

I feel that we must stand shoulder to shoulder in our fight for homœopathy; because its enemies are not only those outside the camp, but also those within the camp. They are those that we may term pacifists. They want to be at peace with the Old School, to hobnob with its members and be recognized

by them. We have no hope for ourselves except by the recognition of our principles to the extreme. The man who talks of pacifism, whether in medicine or in patriotism, should be dreaded. His propaganda is for evil only. We have much to learn from our friends in the Old School, and one of the best things is their solidarity. They are united in every effort they make. Let us take this lesson to heart, and be as united as they have been; and there is no doubt that homœopathy will come to its own—because, turn where we will, we find that the Old School is adopting the Law of Similars. I said to an Old School man, "Show me an advance that you have made that is not based on the principle of similars? All your vaccine treatment belongs to the idea of *similia*." He said, "I am afraid you are right;" and it is true that when we go a little further and take up the newer instruction that we are receiving from those working on the organs of internal secretion, we shall find more and more that every thought that Hahnemann gave us a century ago is being confirmed by the most recent investigations regarding the action of internal secretions. His whole theory is explained by the symptomatic relationship shown by those who have investigated the matter to exist between hypothyroidism and hypopituitarism. We find that these symptoms as described by Hahnemann are accurately defined and almost verbally repeated by present-day authors.

On motion the report was accepted.

Adjourned at 12 M.

SECOND SESSION.—Tuesday afternoon, September 16, 1919. The meeting was called to order by the President at 2.30, and was immediately turned over to Dr. H. G. Carmalt, of Pittsburgh, Chairman of the Bureau of Homœopathic Institutes and Clinical Medicine. It included the following papers: R. W. McClelland, Pittsburgh, "Gastricism;" John C. Calhoun, Pittsburgh, "A Flu Experience;" Clarence Bartlett, Philadelphia, "A Review of the Influenza Epidemic as Observed at Hahnemann Hospital."

The latter two papers were discussed together by Drs. E. A. Krusen, Henry F. Schantz, John G. Wurtz, H. G. Carmalt, John C. Calhoun and Clarence Bartlett. H. G. Carmalt, Pittsburgh, "Hookworm Disease—A Method of Treatment;" William Steele, Philadelphia, "Social Service—Its Application in Internal Medicines;" William W. Van Baun, Philadelphia, "Factors in the Prognosis of Chronic



Interstitial Nephritis." Discussed by Drs. William Steele, Clarence Bartlett and Dr. Wm. Van Baun. G. Harlan Wells, Philadelphia, "Syphilitis of the Cardio Vascular System;" William R. Williams, Philadelphia, "Chronic Bronchitis with Emphysema and Asthma;" Harry M. Eberhard, Philadelphia, "Gastric Observations in Pulmonary Tuberculosis" (read by Dr. Conley); Ralph Bernstein, Philadelphia, "Falling Hair—Causes, Prevention and Treatment with Ultra-Violet Radiation;" G. Morris Golden, Philadelphia, "Prevention and Prophylaxis of Cardiac Diseases."

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY—Joseph V. F. Clay, Chairman. A. C. Shute, Pottstown, "Ophthalmic Points by a General Practitioner;" P. A. Tindall, Philadelphia, "Conservation of Vision;" L. E. Marter, Philadelphia, "Conservative and Radical Tonsil Surgery;" G. J. Alexander, Philadelphia, "Empyema of the Maxillary Antrum;" F. C. Peters, Philadelphia, "Personal Experiences with Mustard Gas and its Effect Upon the Eyes." (Discussed by Drs. Gilbert J. Palen, Irwin D. Metzger, Howard Terry, Jr., P. H. Gerhardt, J. V. F. Clay, J. W. Stitzel, G. J. Alexander.)

TUESDAY EVENING, 8 to 10 o'clock (Closing of Afternoon Bureaus.) PAEDODOLOGY: Margaret Hassler, Chairman. Frank B. Edmundson, Pittsburgh, "The Early Recognition of Tuberculosis in the Child of Pre-School Age." (No discussion.) Dorothy Child, Chief of Division of Child Hygiene, State of Pennsylvania, "Child Hygiene." Julius Levy, Chief of Division of Child Hygiene of State of New Jersey, "The Problem of the Undernourished Child of Pre-School Age." (These papers were discussed by Drs. C. Sigmund Raue, Howard Terry, Jr., Dorothy Child, Julius Levy.) C. Sigmund Raue, Philadelphia, "Hypertrophic Pyloric Stenosis in Infants." (Discussed by Drs. Jno. E. James, Julius Levy, and C. Sigmund Raue.) John G. Wurtz, Pittsburgh, "The Laboratory as an Aid in the Diagnosis of Diseases of Children." Albert R. Garner, Norristown, "Early Recognition of Mental Defectives."

FOURTH SESSION, WEDNESDAY MORNING, 9.30 to 1 o'clock. The meeting was called to order by the President at 9.45 A. M.

The Report of the Legislative Committee, postponed from the previous morning, was read by Dr. E. A. Krusen, of Norristown.

It was moved and seconded that the report be printed in the *HAHNEMANNIAN MONTHLY* as representing the views of the State Society. Carried.

DR. KRUSEN said: "These reports will be printed, so you will get all of this through the Journal; but I want to state briefly that up to date we have received only a little over \$2,800.00 from the medical profession of Pennsylvania for our work; and I have a report here giving the contributions from the different counties. I also have an individual report, which I have kept for reference, of every member that has contributed. Out of this sum the homœopathists of Pennsylvania have contributed \$240.00. That is not quite up to our proportion. We should have more because we have about 11,500 doctors in Pennsylvania, and 1,050 are homœopaths.

"At the request of the Conference, I want to present a resolution asking for the endorsement by this Society of Medical Legislation Conference, so that we may have the backing of our own State Society."

The resolution offered was referred to the Resolutions Committee.

Dr. Weaver appointed as members of the Resolutions Committee Drs. Frank C. Benson, of Philadelphia; R. L. Piper, Tyrone, and J. D. Elliott, Philadelphia.

There were other names added to the list of applicants for membership which were referred to the Board of Censors.

It was moved and seconded that the Secretary cast a ballot for the election of the applicants previously reported to membership. The motion was carried.

The President then resigned the chair to the Chairman of the Bureau of Surgery, Gynecology and Obstetrics, Dr. H. L. Northrop, of Philadelphia.

**SURGERY, GYNECOLOGY AND OBSTETRICS:** Leon T. Ashcraft and F. C. Benson, Philadelphia, "Presentation of a New Instrument Especially for the Application of Radium to Tumors of the Urinary Bladder." John A. Brooke, Philadelphia, "Amputations, Treatment of Stump and Fitting of Artificial Limbs." Dr. R. C. Casselberry, Chester, "Indications for and Results of Bone Plating and Inlayings."

**BUSINESS—NOMINATION OF OFFICERS, WEDNESDAY:** At 11 o'clock the work of the Bureau of Surgery, Gynecology and Obstetrics was interrupted for a short time in order to attend to the business set for this hour. The President took the chair

and called for nominations to fill the offices for the ensuing year.

The President, Dr. Weaver, stated that these nominations would be acted on at 11 o'clock the following morning, and then turned the meeting over again to the Chairman of the Bureau of Surgery, Gynecology and Obstetrics, Dr. H. L. Northrop. The interrupted program of that bureau was then resumed.

Dr. Casselberry's paper was discussed by Dr. John A. Brooke. T. Lawrence Doyle, Pottsville, "Duties of the Regimental Medical Officer of the British Expeditionary Forces." C. Albert Bigler, Jr., Philadelphia, "Another Country Heard from About the War." John Dean Elliott, Philadelphia, "Some Surgical Lessons of the War." C. Seaver Smith, New Haven, Conn., "Surgical Experiences with the British Expeditionary Forces." James G. Spackman, Wilmington, Del., "The Intelligent Use of Carrel-Dakin Solution." Discussed by Drs. George Moreland, R. W. McClelland, H. L. Northrop and John Dean Elliott. F. M. E. Howell, Reading, "Some Experiences with the Homœopathic Remedy in Surgical Cases." D. Bushrod James, Philadelphia, "Postoperative Treatment of Lower Abdominal Cases," (Read by title.) N. F. Lane, Philadelphia, "Up-to-date Conclusions on the Treatment of Retro-displacements." A. B. Webster, Philadelphia, "Gastric Ulcer."

The remaining papers in the Surgical Bureau were postponed until the afternoon session. The Bureau of Surgery, Gynecology and Obstetrics then adjourned for the time being and the President of the Society called on Dr. Sawyer, President of the American Institute of Homœopathy to say a few words. The Bureau finished after the session on *Materia Medica* by presenting the following papers: G. Willis Hartman, Harrisburg, "Mammary Carcinoma." Discussed by Dr. H. L. Northrop. Herbert P. Leopold, Philadelphia, "Surgery of the Gall Bladder." Deacon Steinmetz, Philadelphia, "Personal Experiences with a New Antiseptic." Everett A. Tyler, Philadelphia, "The Responsibility of the Anesthetist." Discussed by Drs. H. L. Northrop and Everett A. Tyler. Herbert L. Northrop, Philadelphia, "The Radical Cure for Femoral Hernia by the Inguinal Route."

FIFTH SESSION—WEDNESDAY AFTERNOON, September 17, 1919. The meeting was called to order at 3 P. M., by



the President, who immediately turned the meeting over to the Bureau of Materia Medica and Provings, Dr. Wm. B. Griggs, Philadelphia, who called for the first paper. Wm. A. Seibert, Easton, "Authentication, Validation and Clinical Verification of the Homœopathic System: A Practical Suggestion and a Warning." (Read by Dr. H. I. Klopp.) Discussed by Drs. A. N. Korndoerfer and Wilmer Strong. Oliver Sloan Haines, Philadelphia, "Letting go of the Essentials." W. F. Baker, Philadelphia, "Research Work in Gelsemium, Semp. and Bryonia in Influenza." Discussed by Drs. W. H. Tomlinson, John G. Wurtz, O. S. Haines, Howard Terry, Jr., Walter Strong and W. F. Baker. H. O. Williams, Lansdale, "An Allegory with a Prologue." Thomas H. Carmichael, Philadelphia, "The Dose." William B. Griggs, Philadelphia, "A Proving of Menthol from the Hering Laboratory."

WEDNESDAY EVENING.—Banquet, entertainment.

SIXTH SESSION, THURSDAY MORNING, September 18th. The meeting was called to order by the President at 9.45 A. M. The President read the list of names of new applicants for membership, which were turned over to the Board of Censors for action.

On motion of Dr. Metzger, the Reports of the Committee on Resolutions and the Committee on President's Address were deferred until after the election at 11 o'clock, and also the matter of the contract to be made with the HAHNEMANNIAN MONTHLY.

Dr. Clarence Bartlett presented the following resolution:

WHEREAS, There is an evident desire on the part of some of our members to provide a method by which one fee will admit to both County and State Societies.

*Resolved*, That the President appoint a committee to consider the feasibility of the plan and report at the next annual meeting.

Dr. Bartlett said that he did not feel sure whether it would be possible to carry out this plan or not, but stated that the Old School had such an arrangement.

The resolution was seconded and carried.

Dr. Weaver appointed as members of this committee the following: Dr. Clarence Bartlett, Philadelphia, Chairman; Dr. I. L. Moyer, Columbia; Dr. E. A. Krusen, Norristown; Dr. I. D. Metzger, Pittsburgh; and Dr. George Mackenzie, Philadelphia.

At 11 o'clock the election of officers resulted in the following: President, Dr. R. L. Piper, Tyrone; First Vice-President, Dr. George W. Hartman, Harrisburg; Second Vice-President, Dr. John C. Calhoun, Pittsburgh; Secretary, Dr. J. M. Kenworthy, Philadelphia; Treasurer, Dr. Ella D. Goff, Pittsburgh; Necrologist, Dr. H. F. Schultz, Philadelphia; Censor, Dr. N. F. Lane, Philadelphia; Trustees, Drs. J. W. Stitzel, Hollidaysburg, G. H. Wells, Philadelphia; Harry S. Weaver, Philadelphia.

The report of the Committee on the President's Address was read by the Chairman of the Committee, Dr. G. H. Wells, as follows:

The Committee has gone over the very able and comprehensive address of Dr. Weaver, the President of the State Society, and wishes to thank the President for bringing to our attention matters that should be of interest to every broad-minded physician. The Committee wishes to emphasize what the President has said in regard to the part played by homœopathic physicians in the World War. Military men everywhere have recognized the value of our work, and it is universally conceded that the fitness and competency of our practitioners was surpassed by no other group of medical men.

The President has done a wise thing in calling the attention of the profession and of the public to the serious consequences that have resulted from the increasing lack of physicians, especially in the rural districts, and the unnecessarily long and expensive course of medical and pre-medical education now required before a man can secure a medical license in Pennsylvania and in other States. This is excluding from the profession large numbers of men who are necessary to the growth of the profession and to the maintenance of public health. Many of these unnecessary requirements have had their origin in the jealousy which exists between the Medical Boards of the various States, each Board being determined that the Medical Board of the other State shall not outdo them in the number of hours or in the financial expenditure required before a Medical License will be granted. It seems almost inconceivable that such purile rivalries should sway the judgment of men whose only concern should be the interest of the profession and of the public, but such, unfortunately, is the case. We believe that the Homœopathic Medical Society of Pennsylvania should exert every influence to raise the

standard of medical education from one based merely upon "hours" and "counts" to a standard of *efficiency* in teaching and of *service* to the public. Were this done, it is universally conceded that one year of pre-medical work is ample to prepare a student for his medical course and it is the opinion of a very large proportion of the medical profession that, with the co-operation of the High School authorities, men could be very easily so prepared in these institutions as to enable them to immediately begin the study of medicine after graduating from the High School. This, with a Four Year Medical Course, efficiently conducted, and one year of hospital training, would give any intelligent man ample information and training to enable him to engage in the practice of medicine.

In regard to federation with the American Institute of Homœopathy, we agree with the President that the State Society should by all means endorse the principle of co-operation and of federation. We feel, however, that we should urge upon the Institute that the proposition should be stated in a more definite manner in order that the advantages and obligations of both sides could be more clearly understood.

Dr. Weaver's appeal on the part of our members to improve the literature of our school and to support our official journal should be heeded by every member. Too much energy has been wasted in the past in criticism and in fault finding. With the proper spirit of encouragement and of hearty co-operation we believe that the literature of our school and the welfare of our Society in general would be materially increased.

G. HARLAN WELLS, *Chairman*.

The Report of the Resolution's Committee was presented by Dr. R. L. Piper, of Tyrone, Chairman of the Committee.

It was moved by Dr. Metzger that the Society approve the action of the Trustees in taking over the HAHNEMANNIAN MONTHLY. The motion was seconded. Carried.

The Business Session adjourned at 9.55 A. M., and the President gave the chair to Dr. Othmar F. Barthmaier, Philadelphia, Chairman of the BUREAU OF PATHOLOGY AND PATHOLOGICAL ANATOMY. Othmar F. Barthmaier, Philadelphia, "The Present Status of Antisera." John G. Wurtz, Pittsburgh, "Intermediate Tumors." Raymond S. Leopold, Philadelphia, "Laboratory Observations of the Influenza Pandemic." Discussed by Drs. John G. Wurtz, R. S. Leopold, Morris M. Fleagle. George A. Hopp, Philadelphia, "The



Present Status of Chemotherapy." Frank O. Nagle, Philadelphia, "Gonorrheal Ophthalmia." A. F. Copeland, Philadelphia, "Malaria." Discussed by Drs. John G. Wurtz, Aug. Korndoerfer, and I. L. Moyer, Columbia.

The Bureau of Pathology and Pathological Anatomy adjourned at 12.30 and the Chairman of the Bureau of Sanitary Science, Dr. H. H. Snyder, Scranton, took charge of the meeting. BUREAU OF SANITARY SCIENCE. Thomas W. Jackson, Asst. Com. of Health, Harrisburg, "Hygiene and Sanitation." David Wilbur Horn, Philadelphia. "Vitamines and Nutrition." Dr. Charles B. Hollis, Capt. M. C., Philadelphia, "Battle Sanitation." H. H. Snyder, Scranton, "Advancement."

The Bureau of Sanitary Science adjourned at 1.15 P. M.

The President called for any business or reports that might yet be made before final adjournment. None being presented he thanked the members and especially his assistants on the program for their hearty co-operation.

Motion to adjourn was carried at 1.17 P. M.

(Signed) IRVIN D. METZGER, *Secretary*.

RESOLUTIONS.—The following resolutions were offered by the committee composed of Drs. Benson, Piper and Elliott:

*Resolved*, That the Homœopathic Medical Society of Pennsylvania endorse the work accomplished by their appointed committee and that this Society shall maintain their representatives on the Medical Legislative Conference, as the Official Legislative Representatives of the Homœopathic Medical Society of Pennsylvania.

*Resolved*, That the following communication be presented to the Philadelphia Chamber of Commerce: "That while appreciating the courtesy extended to us by the Philadelphia Chamber of Commerce, we deplore that the inefficient hotel accommodations of Philadelphia have caused such inconvenience to our members; that we, therefore, request the Chamber of Commerce to use every effort to increase the hotel facilities of this great city, as we believe it would be of interest and surely of convenience to visitors and delegates."

WHEREAS, There is an evident desire on the part of some of our members to provide a method by which one fee will admit to both County and State Societies.

*Resolved*, That the President appoint a committee to consider the feasibility of the plan and report at the next annual meeting.

*Resolved*, That the thanks of the Society be extended to the Philadelphia Chamber of Commerce for the use of its rooms and for the courtesies extended our members by its management.

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NEW MEMBERS.

J. V. Allen, Jr., Phila.	L. H. Hendrixon, New Holland
P. G. Atkinson, Norristown	W. W. Hobart, Pittsburgh
Leroy J. Barber, West Chester	J. A. Hoffman, New Holland
C. O. W. Bartine, Phila.	J. W. Hogan, Phila.
Chas. H. Beebe, Phila.	Chas. B. Hollis, Phila.
Raymond G. Blood, Phila.	Arthur J. Huselton, Phila.
James Brooke, Glenside	F. G. Hutton, Phila.
Chas. M. Brooks, Phila.	Raymond S. E. Hunter, Phila.
Asa F. Copeland, Phila.	G. Chapin Jenkins, Phila.
W. E. Coss, New Brighton	Geo. W. Kirk, Phila.
E. P. Cuthbert, Titusville	Wm. G. Kinsley, Robesonia
Wm. T. Doeble, Phila.	W. Earl Kistler, Swarthmore
W. R. Dunlop, Brookline	A. D. Kisner, Bethlehem
J. W. Ely, Washington	Harold E. Kistler, Ardmore
Jos. C. Ellis, Phila.	Paul E. Kitchen, Olney
J. H. Ervin, Jenkintown	R. L. Kropp, Phila.
Geo. I. Enders, Phila.	R. W. Larer, Phila.
H. J. Evans, Sunbury	Geo. Levis, Phila.
F. W. Faltermayer, Phila.	H. W. Lambert, Phila.
Donald R. Ferguson, Phila.	Earl C. Lyon, Phila.
G. S. Fisher, Lebanon	W. S. McFadyen, Phila.
Andrew Flanagan, Phila.	H. S. McKinstry, Kennett Square
Chas. D. Fox, Ardmore	R. J. McNeill, Phila.
Wm. L. Franck, Phila.	L. E. Marter, Phila.
J. M. Gerhart, Cynwyd	Jno. D. Mast, Reading
Chas. W. Gessler, Phila.	Geo. W. Mays, Phila.
F. O. Gross, Phila.	H. P. Metzger, Phila.
Carrol F. Haines, Phila.	M. Mifflin Mercer, Down- ingtown
D. W. Harner, Phila.	Thos. D. Mills, Harrisburg
Edw. F. Haines, Rutledge	Geo. B. Mitchell, Phila.
E. F. Harper, Shamokin	Robt. McCarty, Jr., Phila.
R. J. Harris, Phila.	Ashton E. Neely, Pottstown
Henry B. Harvey, Phila.	Martin J. Nevinger, Phila.
Howard F. Heinkel, Phila.	J. F. Nowell, Greencastle
Wm. J. O'Neill, Phila.	H. T. Stockton, Phoenixville
R. R. Paxson, Phila.	
Wm. A. Pearson, Phila.	

N. F. Paxson, Phila.	H. H. Snyder, Scranton
M. F. Pettler, Pittsburgh	Thos. M. Snyder, Phila.
Ralph E. Pilgram, Harrisburg	J. A. Stackhouse, Erie
Wm. A. Ploucher, Phila.	J. H. Sterner, Norwood
Jos. W. Post, Phila.	J. Sewell Stewart, Phila.
Henry E. Porter, Coatesville	F. P. Stone, Phila.
J. P. Poitrowski, Pittsburgh	Fred C. Stubbs, Phila.
Wallace E. Prugh, Pittsburgh	H. E. Twining, Pittsburgh
J. H. Reading, Jr., Merion	Harold A. Taggart, Phila.
F. H. Roepke, Phila.	Chas. W. Tuthill, Crafton
H. K. Roessler, Phila.	Chas. W. Ursprung, Phila.
Chas. A. Rowland, Chester	Carl V. Vischer, Phila.
S. Leroy Roth, Conshohocken	R. A. Walther, Phila.
B. K. Russell, Bradford	F. Watson, Willow Grove
W. J. Ryan, Phila.	R. D. Webb, Bristol
H. F. Schultze, Phila.	H. C. Witmeyer, Phila.
Furman R. Shute, Phila.	S. W. Pratt, Coatesville
A. B. Smith, Wilkinsburg	Horace Ewing, Phila.
Ernest B. Smith, Phila.	John M. Barthmaier, Phila.
J. Hunter Smith, Phila.	C. F. Rau, Phila.
Wm. J. Hamer, Pittsburg	Earl B. Craig, Phila.
G. W. Heck, Coatesville, Pa.	R. B. Brown, Waynesboro, Pa.
J. Jack, Collingswood, N. J.	E. S. Snyder, Lancaster, Pa.

## MEDICAL LEGISLATIVE CONFERENCE OF PENNSYLVANIA.

BY E. A. KRUSEN, M.D., NORRISTOWN.

*Mr. President:*

September 15, 1919.

The Legislative Committee, originally appointed with the joint committee, composed of three members from each of the three recognized schools of medicine in Pennsylvania, of which Dr. William Steele, of Philadelphia, Drs. Hillegas and E. A. Krusen, represented the Homœopathic School of Pennsylvania. They held their first meeting Nov. 25th, at the University Club in Philadelphia, when it was deemed advisable to ask the presidents of the three State Societies to increase their membership to five each. This was consented to and the Medical Legislative Conference of Pennsylvania was then made up as follows:

PENNSYLVANIA MEDICAL SOCIETY—Drs. F. L. Van-Sickle, J. F. Culp, L. Webster Fox, G. A. Knowles, Frank Hartman.



STATE HOMOEOPATHIC SOCIETY—Drs. E. A. Krusen, J. Ross Swartz, R. L. Piper, W. Steele, Wm. Hillegas.

ECLECTIC SOCIETY OF PENNSYLVANIA—Drs. M. V. Hazen, E. F. Shaulis, W. S. Glenn, W. O. Keffer, R. E. Holmes.

Meetings were held by this Joint Committee in Philadelphia and Harrisburg at different periods. The principal ones were Jan. 24th at the University Club, Philadelphia, and in Harrisburg on July 25th.

The interests of the people of Pennsylvania and of the Medical Profession of the State were carefully and as conscientiously looked after as it was possible for your committee to do. We were most fortunate in being able to secure the assistance of Robert Height, who gave the Chairman of the Conference, Dr. F. L. VanSickle, the greatest of assistance in legislative affairs and without whom it would have been impossible to have carried on the work so well.

The report can best be summed up by the following reports at our final meeting and which were adopted and referred to the three State Societies for publication, giving a full outline of the work accomplished during the past winter. This is only the beginning of what is proposed by your committee and the committees of the other two schools of medicine to become a permanent Legislative Bureau.

The following are our full reports :

#### FINAL REPORT OF THE MEDICAL LEGISLATIVE CONFERENCE.

The following survey of bills introduced in the Senate and House of Representatives of the State of Pennsylvania, during the nineteen-nineteen (1919) session, relating to medical affairs, are analyzed in the following report: The purpose of the Medical Legislative Conference is to protect, insofar as it can be accomplished, the interests of the medical profession and general public of the State, and the Conference this year decided to request its chairman to attend the sessions of the House and Senate and therein voice the sentiment and opinion of organized medicine relative to any measure that might be introduced. The chairman accepting this duty, has been present at the sessions and has used whatever influence obtainable, to cause the passage of measures beneficial to the people of the State as well as oppose baneful measures.

In the beginning of our legislative campaign we first secured the hearty co-operation and support of the Commissioner of the State Department of Health and his assistants, and from them received the most valuable aid in accomplishing the purposes which we set out to do. We were also able to render to the members of the medical profession, who were also members of the State Senate and House of Representatives forcible arguments for or against the passage of legislation in which we were interested and to a man they gave us their unqualified support. From a review of the experience of the Conference, through its representative, several important matters of legislation appeared prominently. First: The effort of the so-called drugless therapists to enact legislative measures authorizing them to practice medicine by the laws, with the same authority as is now vested in the medical practitioner, under the medical practice act, without acquiring medical education necessary to qualify them to do so. We are pleased to say through the efforts of the Conference, with the assistance of the active co-operation of the officers and members of the medical societies of the State, these measures so introduced were defeated on the floor of the House and in the Committee on Public Health and Sanitation of the House and Senate. It must be remembered, however, that this will not close the chapter for future efforts on the part of those who seek to practice the healing art in the State of Pennsylvania. Greater effort in the future, than that which has been manifested in the past, will be necessary in order that the practice of medicine for the interest and welfare of the people of this State may be protected.

Second: The ever active effort on the part of many misguided people of this State to introduce measures not in accord with results achieved by medicine in the past history of this country and of the world, by the introduction of measures which would retard the efforts of the medical practitioners to protect the public health by the restriction and prevention of communicable diseases, was deeply as prominent at this session as it has ever been in the past. Three measures were introduced to prevent the physicians from vaccinating the people of the State, notwithstanding the frequent appearance of smallpox and the dangers of the spread of that loathsome disease. It is well to point out that an organized effort must continue to be made to prevent interference in the thera-

peutic application of vaccination by these misguided people, and more active steps should be taken by organized medicine to educate the layman and especially to bring to the notice of the probable members of the session of the Legislature of 1921 the careful analysis of measures which might be presented having a bearing on the subject.

Third: A miscellaneous group of legislation was introduced, relating to vivisection, the work of the medical colleges, the anatomical board, health and sanitation, housing regulations, the registration of nurses, the licensing of medical men who have been in the service, the reporting of communicable diseases and other bills of a kindred nature, all of which impressed the Conference with the necessity of being prepared to intelligently review the merits and demerits of each of these legislative problems. The medical profession must realize that the mere matter of medical practice does not rest alone upon the privileges conferred upon the graduate of medicine and the protection of the medical practice act. A broader and more comprehensive method of securing information, and the application of a system by which we can be prepared to meet any legislative emergency, which may appear, should be given careful and mature consideration by organized medicine. Not only should this be our effort during the legislative years, but also during its interim.

Fourth: Social Insurance is a problem with which every practitioner of medicine in the State should and must become interested. The report of the commission to make a sickness survey of the State of Pennsylvania, submitted a report with their findings, but did not recommend for this session, the enactment of an insurance measure. The Governor of Pennsylvania was authorized by a joint resolution to appoint a committee to continue this study and submit its report to the session of 1921. No one at the present time is able to anticipate the nature of the report which may be submitted, nor the sentiment of the people of the State, relative to a Health Insurance Bill, which may be a possibility during that session. It should be plain, however, that with continued agitation of this problem in other States, that public sentiment might be of such a mind, that Health Insurance will be presented to the profession for its serious and active consideration.

The provisions of the Workmen's Compensation Act of



1915 are familiar to every member of the medical profession. The Medical Legislative Conference has devoted much time and effort to influence amendments to this act, whereby the financial return for the treatment of industrial accidents should be adequate. We are pleased to report that these efforts have been successful in the introduction in section 306, clause (e), of this act, of such changes as will give the industrial surgeon the privilege of treating the accident case for thirty days, the maximum limit of payment to be one hundred dollars (\$100), and the elimination of the word "major." Hospital care and charges are separated from the medical and surgical provisions and these charges are also limited to one hundred dollars (\$100), by a rule of the board.

It can be seen, therefore, from the foregoing that great improvement has been accomplished in this section of the act and many of the misunderstandings of the past eliminated.

In conclusion we can say that taken as a whole there has been no legislation enacted at the legislative session of 1919 which can be construed in any way as being detrimental to the interests of the medical fraternity, while on the other hand we feel that we have accomplished much that will prove beneficial to us in the practice of our profession.

#### TO THE OFFICERS AND MEMBERS OF THE MEDICAL LEGISLATIVE CONFERENCE.

Your chairman, having completed the duty assigned him, as Medical Representative during the 1919 session of the Senate and House of Representatives of the State of Pennsylvania, that of caring for the interests of organized medicine, cannot close his duties without making special mention of the many courtesies and favors extended to him during the session.

It seemed almost too good to be true when in the final hours all measures upon which we had based our hopes, culminated in the passage of bills, by which the medical profession will be greatly affected.

It would not have been possible for one individual to have sufficient influence to cause the passage of these measures, as well as hinder the passage of vicious acts, were it not for the thorough co-operation your chairman found was extended to him this year.

I first wish to express my deep appreciation of the

courtesy and favors shown my by Colonel Edward Martin, Commissioner of Health of the State of Pennsylvania, and his associates. While in all things we might not have agreed, the success of the bills of the department and the success of the co-operative action made it possible in the final issue for all to be satisfied with the results. The department extended to me desk room, as well as many other favors, of which I desire the Conference to be cognizant, so that they may appreciate what the department did for us.

The Bureau of Labor and Industry also extended favors and I wish especially to thank Dr. Francis D. Patterson, Chief of the Division of Hygiene, for many kind acts during the session.

The medical members of the House and Senate were early in the session made acquainted with the fact that the representative of the Medical Legislative Conference stood ready at all times to offer such information, advice and co-operation as they might desire. Your chairman at the same time made it plain that we wished to exert our influence in that the interests of organized medicine and the medical fraternity, and also the welfare of the people of this great Commonwealth, should receive our most earnest attention.

To Honorable Summerfield J. Miller, M.D., Senator from Clearfield County and Chairman of the Committee on Public Health and Sanitation, your chairman wishes to extend his most sincere thanks for the ready and willing co-operation in the work which he was unfamiliar with and with which Senator Miller, from his long and varied experience in the Senate, could and did furnish the proper information and procedure. It would please your chairman exceedingly if the voters of Clearfield County, the medical profession of that county and the State were acquainted with the work which Senator Miller has accomplished in the past, frequently unassisted, in the interests of the medical fraternity. We trust he will be returned many times to continue the work which he has so ably accomplished in his position as chairman of the Committee on Public Health and Sanitation.

We wish to extend our thanks to Honorable George Woodward, M.D., of Philadelphia County, who assisted your chairman in every way possible.

Your chairman wishes to call special attention to the Workmen's Compensation Act and to extend to Honorable

Jos. G. Steedle, M.D., of Allegheny County, his thanks for the manner in which assistance was rendered him by Dr. Steedle, in the passage of the amendment to the act. Early in the session Dr. Steedle introduced a bill amending the Workmen's Compensation Act, which acted as a safety measure in preventing the medical profession from receiving the same treatment, possibly, that they had in former sessions, namely, being ignored. Through Representative Steedle's interest we were able to deliver to the medical profession an amendment which will be of great benefit to those who do industrial surgery. Your chairman would also like to have this information communicated to the voters of Allegheny County of Representative Steedle's district, to inform them that they have a valued representative, not only in medical matters but in the keen, active interest which he demonstrated as a representative of the people of his district and of the State.

I wish to extend my thanks to the other five medical members of the House of Representatives for their assistance and co-operation during the session.

Your chairman specially refers to the chairman of the Committee on Public Health and Sanitation, Honorable Sigmund J. Gans, of Philadelphia County, who, although not a physician, has for many years been chairman of this important committee, and who, during the session, lent every effort to assist your chairman in defeating vicious measures and in the passage of good ones. To the voters of Representative Gans' District, we believe that he should be commended and the State should realize that he is a man who has shown ability during the past session as a representative of the people and who is worthy of their continued support.

To Attorney General Schaffer and his assistants your chairman wishes to extend his sincere thanks for favors extended to him during the framing of the Workmen's Compensation Act, as well as other measures. Your chairman wishes to say (and I believe the entire membership of the Conference will echo this sentiment) that his Excellency, William C. Sproul, Governor of the great State of Pennsylvania, has proved himself the man of the hour. He extended to the medical profession, through their representative, every possible assistance and encouragement that we should receive a fair deal and that no obstacle from his office would prevent our having a proper hearing, with the result that for the first time



in many years have we, as the servants of the people, been admitted to the conferences wherein legislative enactments materially influencing our future were framed. To the Governor and his Secretary we wish to say that no words of the chairman of this body are adequate to express our appreciation of their magnanimous co-operation.

To Doctor J. M. Baldy, Chairman of the Bureau of Medical Education and Licensure, I wish to express my thanks for the many kind letters of information and advice relative to measures introduced, affecting his department. We feel that without Doctor Baldy's co-operation that errors in the acts would have occurred. It is eminently satisfactory that the passage of certain of the bills will make it possible to strengthen the position of the Bureau of Medical Education and Licensure, in relation to the irregular practice of medicine in the State.

In closing, I desire to express my appreciation of the good work of the Secretary-Treasurer, Dr. E. A. Krusen, who assisted me in every effort to carry on the work this year.

To Drs. George A. Knowles, Chairman of the Committee on Public Policy and Legislation, of the Medical Society of the State of Pennsylvania and a member of the Conference; also to Dr. L. Webster Fox, of Philadelphia, I wish to extend my thanks for their aid.

It is also most fitting to say how I appreciate the work of my assistant, Mr. Robert Height, of Philadelphia, without whose aid I would have been able to accomplish but little in legislative affairs. I am sure that if this movement is continued and if Mr. Height is available, whoever carries on this work during the next session should endeavor to secure his services and co-operation.

Thanking the members of the Conference for the trust and confidence they reposed in me, without any knowledge of my previous ability, and their hearty co-operation in every respect, I remain,

Sincerely yours,

FREDERICK L. VANSICKLE,

*Chairman of Medical Legislative Conference.*

## MEDICAL LEGISLATIVE CONFERENCE.

A REVIEW OF BILLS INTRODUCED IN THE HOUSE OF REPRESENTATIVES AND SENATE OF THE STATE OF PENNSYLVANIA, SESSION OF 1919, BY THE CHAIRMAN OF THE MEDICAL LEGISLATIVE CONFERENCE, SUBMITTED FOR INFORMATION.

Your chairman, having assumed the duty assigned him, of attending the sessions of the House and Senate during the session of 1919, herewith submits the list of bills which have come before us, either for favorable action and assistance in passage or to use influence to cause the same to be kept in committee or defeated on the floor of the House or Senate.

HOUSE BILL NO. 120.

This act was to amend section 12 of "An act to provide for the more effectual protection of the public health in the several municipalities of this Commonwealth."

As this was not a good amendment and not supported by the Department of Health, it was reported with a negative recommendation by the Committee on Public Health and Sanitation.

HOUSE BILL NO. 215.

"An act to provide a just and equitable method of distributing money appropriated for the relief of the poor requiring medical and surgical treatment in hospitals and sanatoria in this Commonwealth not under the absolute control of the State and unable to pay for the same."

The provisions of this bill were not satisfactory, would produce no good in application and the bill was, therefore, reported with a negative recommendation by the Committee on Public Health and Sanitation.

HOUSE BILL NO. 260.

This bill was introduced to continue the commission on health insurance, as requested by the report of the commission appointed in 1917.

The bill passed finally in the House and passed third reading and final passage in the Senate June 17, 1919, and has been signed by the Governor.

The passage of this Act and Resolution No. 9 of the House, which was approved by the Governor March 19, 1919, assures the people of the State and the medical profession that a commission will be appointed and continue the sickness sur-

vey until the session of 1921 when, if their findings prove to them that health insurance as a compulsory measure in the State of Pennsylvania is necessary, a bill for that purpose will be introduced.

HOUSE BILL No. 375.

"An act providing for and regulating the sterilization of certain persons and providing for the payment by the several counties of the expenses in connection therewith."

Our efforts were made to keep this bill in committee, as we do not believe that the State of Pennsylvania is prepared, nor the medical profession willing, to go on record as favoring this drastic measure.

It was reported with a negative recommendation by the Committee on Public Health and Sanitation.

HOUSE BILL No. 376.

"An act forbidding the advertising, publishing, selling, etc., of information tending to interfere with or diminish the number of births of human beings in the Commonwealth of Pennsylvania."

This bill passed the House and was on second reading in the Senate when, from information obtained from good legal authority, we opposed the final passage of this measure, which might be used to work severe injury to the medical profession.

It was re-committed to the Committee on Public Health and Sanitation of the Senate, May 7, 1919, and was never reported out.

HOUSE BILL No. 415.

This was an act to regulate the practice of optometry and was one of three acts which the committee considered best to oppose, and it was re-committed on second reading to the Committee on Public Health and was not reported out.

HOUSE BILL No. 460.

This is the second bill introduced regulating the practice of optometry and was also referred to the Committee on Public Health and Sanitation and was not reported out.

HOUSE BILL No. 461.

This was the third optometry bill and it, too, was referred to the Committee on Public Health and Sanitation and was not reported out.

HOUSE BILL No. 497.

"An act prohibiting advertisements relating to the treat-



ment of diseases of the generative organs and prescribing penalties."

This bill passed the House early in the session and continued in the Senate until May 7, 1919, when it was re-committed to the Committee of the Senate on Public Health and Sanitation.

Believing that this bill was a good one, we made effort to have the bill reported out, but learned of strong opposition, which eventually we were able to have removed and the bill was reported out and passed finally June 25, 1919, and has been signed by the Governor.

HOUSE BILL No. 510.

This is known as the "Goehring Osteopathic Board Bill," which would have given the osteopathic practitioner the same privileges which are extended to practitioners of medicine under the license of the Bureau of Medical Education and Licensure.

This was the most strenuously fought bill on the part of the chairman, of the session. Communications were sent to every county society in Pennsylvania, urging influence with senators and representatives to defeat this measure.

It was postponed until April 9, 1919, and came up on April 29, 1919, and defeated in final passage by vote of 126 against and 53 for its passage.

Reference will be made to the companion bill in Senate Report.

HOUSE BILL No. 576.

"An act to prohibit medical treatment or surgical operations upon any person without the consent of such persons or their parents or guardians and prescribing penalties for violations."

This was the first of three anti-vaccination bills which had a hearing before the Committee on Public Health and Sanitation.

This bill was re-committed to the committee on April 28, 1919, and was not reported out.

The same disposition was made of the other two anti-vaccination bills.

HOUSE BILL No. 635.

An act relating to milk, making it possible to change the percentage of butter fats and milk solids and providing a standardization of milk, etc.

Your chairman received communications from Philadelphia opposing this measure, as it would open the door for dealers to furnish milk with reduced butter fat and solids and would be detrimental to the interests of the babies of the State.

It was, therefore, opposed by your chairman and re-committed to the Committee on Agriculture March 11, 1919, and was not reported out.

HOUSE BILL No. 661.

This was a bill introduced by the Undertakers' Association to increase the amount given for the burial of unclaimed bodies.

It was opposed by the Anatomical Board, on the ground that it would limit the possibility of obtaining material for dissection, and an amendment was introduced into the bill which we believe will allow the Anatomical Board to obtain sufficient material for anatomical purposes.

The bill passed finally and was approved by the Governor.

HOUSE BILL No. 673.

This was the second sterilization bill, to sterilize inmates in institutions, and was sufficiently urged by its friends to bring it before the House, but it was defeated on final passage May 12, 1919.

HOUSE BILL No. 913.

This was an act to amend the charters of institutions of learning, etc., relieving institutions teaching the practice of chiropractic only from the provisions of the sections of the act.

This bill would have allowed the drugless therapists to come under charter regulations and make their own provisions.

It was reported with a negative recommendation by the Committee on Judiciary Special.

HOUSE BILL No. 972.

This was one of the three prohibition measures and would have affected particularly the physicians, dentists and druggists. Several amendments were put in the act prior to its appearing for third reading, but it was defeated on final passage June 10th.

HOUSE BILL No. 1031.

The Steedle Bill—"An act to amend clause (e) of sec-

tion three hundred and six of an act approved the second day of June, one thousand nine hundred and fifteen"—the Workmen's Compensation Act.

This bill was introduced as a checkmate in case the Workmen's Compensation measures as proposed by Mr. Mackey would not be considered, and would have been urged for final passage had not the Governor, through the Attorney General's office, caused the Workmen's Compensation Act to be rewritten with favorable amendments for the physicians and hospitals.

This bill was never called from committee; due to the fact that the measure passed the House and Senate, as provided by the Attorney General's Office.

HOUSE BILL No. 1051.

This was the second anti-vaccination bill and was reported with a negative recommendation.

HOUSE BILL No. 1052.

"An act to provide for the more effectual protection of the public health in the several municipalities of this Commonwealth in so far as it affects counties having a population of less than seventy thousand."

This also was a measure not endorsed by the Department of Public Health and was never reported out by the Committee on Public Health and Sanitation.

HOUSE BILL No. 1130.

"An act to prohibit experiments upon living dogs and providing a penalty for the violation thereof."

This was the anti-vivisection measure and was re-committed to the Committee on Public Health and Sanitation on May 2, 1919, with the assurance that it would not be reported out.

A final effort was made on the part of friends of this bill on June 18th, by obtaining the signatures of the members of the committee and it was presented for third reading June 19th and defeated on final passage.

HOUSE BILL No. 1154.

"An act to provide for more effectual protection of public health in the several municipalities of this Commonwealth."

This was not favored by the Department of Health and was reported with a negative recommendation by the Committee on Public Health and Sanitation.



## HOUSE BILL No. 1484.

This was an act to amend clause (e) of section three hundred and six of the Workmen's Compensation Act.

This act was not pushed on account of the attorney general's bills and was not reported out of the Committee on Labor and Industry.

## HOUSE BILL No. 1550.

"An act to protect the public health and welfare by the control of venereal diseases."

This was an effort to dictate the policy of the Department of Health and was not favored, either by the department or your chairman, and was not reported out of the Committee on Public Health and Sanitation.

## HOUSE BILL No. 1580.

This bill was introduced by Representative Sprowls, a medical member of the House, and would have paid \$1.00 each for reporting births and deaths.

This bill arrived at the time of final passage, but was not favored by the members of the House, who were against the medical profession and would not have it passed and it was dropped from the calendar June 17, 1919.

## HOUSE BILL No. 1642.

This was a measure introduced by the Department of Health in regard to requiring reporting of communicable diseases and giving the department increased powers.

Requests from members of the profession were made in writing to your chairman for the introduction of a bill to pay for reporting births, deaths and communicable diseases, and, inasmuch as the Department of Health had no measure to propose, an amendment was placed in this bill to pay a fee of not less than 25 cents for information and report of each case of contagious disease. This amendment was not opposed by the department, but was vigorously opposed by members of the House, with the result that the bill was defeated on final passage May 27, 1919.

A vote to reconsider the bill on May 28th, carried. The bill was re-reported as amended by striking out this clause and passing finally in the House on June 10th, and in the Senate June 24th, and has been signed by the Governor.

The chairman wishes to refer to this bill particularly, as an answer to the many requests by members of the profession that the Department of Health, of the municipality,

compensate the physicians for reports of births, deaths and communicable diseases. For the first time in many years an opportunity was presented to place this request before the Assembly of the State of Pennsylvania, and we now have an answer by the representatives in a defeat of these provisions; hence the profession must seek other means of compensation for such reports.

#### SENATE BILLS.

##### SENATE BILL No. 217.

"An act to regulate the practice of drugless therapeutics and creating a board of licensure."

This bill was reported to the Committee on Public Health and Sanitation of the Senate and action on the same was indefinitely postponed.

##### SENATE BILL No. 248.

"An act to amend sections of the Act of the State Board of Examiners for the registration of nurses."

This bill proposed to change the personnel of the board, by dropping the physicians of the board and creating a board composed entirely of nurses.

Efforts were made to amend this act by providing three physicians and two nurses as in the original act, but a compromise was effected with the commissioner of health and others and on final passage the act provided for two physicians and three nurses as members of the board.

This act was not favored, in its amendments, by your chairman, but after the compromise was effected no further influence was used for the bill.

##### SENATE BILL No. 446.

An act to amend the State Board of Osteopathic Examiners act, and was considered a companion bill to House Bill No. 510, which was defeated on the floor of the House.

Inasmuch as the House bill introduced by Representative Goehring was defeated, the Committee on Public Health and Sanitation indefinitely postponed this measure.

This action was not on the part of the committee, but by virtue of opinions expressed at the hearing before this committee, which persuaded them that this was not a good act to pass.

## SENATE BILL No. 613.

"An act to provide for the erection, construction, equipment, maintenance and management of a State pathological X-ray and chemical laboratory and making an appropriation therefor."

This bill was referred to the Committee on Appropriations and indefinitely postponed.

## SENATE BILL No. 614.

Known as the "Housing Bill," to increase the power of the Department of Health as to the sanitation of dwellings and was favored by your chairman, but opposition to this measure was so strong that it was re-committed to the Committee on Public Health and Sanitation, and action indefinitely postponed.

## SENATE BILL No. 725.

An act providing for the granting of certificates of licensure to practice medicine to persons who served in army and navy.

This act was amended with the approval of the Bureau of Medical Education and Licensure, and was passed and signed by the Governor.

## SENATE BILL No. 732.

This was known as the "Leslie Bill," introduced by the Department of Health, to regulate the possession, control, dealing in, etc., of certain drugs, and was of such a sweeping nature that the druggists and the medical profession entered strong protest at the hearing against its passage and the bill was withdrawn by the Commissioner of Health.

## SENATE BILL No. 868.

An act to amend an act providing for the admission of insane patients and fixing compensation for examination.

This bill provided a fee of \$10 for the attorney and \$5 for the physician.

We opposed this unequal compensation in committee and the bill was re-committed to the Committee on Public Health and Sanitation on May 13, 1919, and action indefinitely postponed.

## SENATE BILL No. 975.

This was House Bill No. 1239, introduced by the Department of Health and increased the powers of the department to regulate vaccination, correcting omissions in the act of 1895.



This bill passed the House and Senate and was signed by the Governor, which now gives the Department of Health absolute control in regard to vaccination regulations.

SENATE BILL No. 993.

Amending sections 306, 307, 308 and 309 of article 3 and articles 4 and 5, of Workmen's Compensation Act.

Section 306, clause (e) was amended by striking out the words "major operation," extending the time of treatment of the employee from 14 to 30 days and increasing the compensation from \$25 and \$75 to \$100; separating the compensation of the physician from hospital charges and furnishing hospital care for 30 days, and the cost of hospital treatment and supplies to be at the prevailing charges, the board fixing the limit of \$100 for said services.

This amendment to the Workmen's Compensation Act was the most important work accomplished by your chairman during the entire session and, if no compensation to him was given, he feels well paid in that the medical profession of the State of Pennsylvania has for the first time in the five years since the beginning of the introduction of this measure made an impression upon the law makers of this State, with the above result. This in itself is sufficient argument to encourage the Medical Legislative Conference to request of the medical profession a continuance of this movement and arranging plans whereby legislative measures may not only be obstructive, but that constructive legislation may be introduced when the proper time arrives.

FREDERICK L. VANSICKLE, *Chairman,*  
*Medical Legislative Conference*

## HOW TO USE THE REPERTORY.

BY

OSCAR E. BOERICKE, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of Philadelphia County.)

"LABOR ET MEDITATIO"—thus resounds that apothegm of the Roman historian through the corridors of the centuries. Without unflagging industry from the humblest bit of drudgery to the most finished scientific research, coupled with mature and judicial reflection, all human strivings toward attainment of success will prove futile, and of necessity, discouraging. And how tellingly so, in that noble domain of the amelioration and cure of mortal ills and suffering.

The worker in the mine of homœopathic symptomatology, delving for the ore that will crown his toilings with therapeutic success, must be cognizant of several personal prerequisites. Firstly and pre-eminently, sincere and consistent faith in the validity and efficacy of the homœopathic drug pathogenesis. Secondly, unbiased recognition of the *imperfect* scientific equipment of the early heroic drug provers, manifestly hampered in their methods of experimentation and interpretation, by their "*termini technicæ*," yielding an unparalleled, invaluable, yet by no means flawless, perfected symptomatology. Thirdly, indomitable courage to envisage and surmount that inevitable retinue of curative disappointments and failures, so frequent in their occurrence to a busy practitioner.

Truly, how often has the well-meaning, inexperienced homœopathic tyro had his virginal faith shattered on the shoals of an early disillusionment, ever afterward hopelessly floundering about, in the lethal pools of a crass therapeutic nihilism, or mayhap, covertly steering his craft into the alluring but subtle deep of indiscriminate drug palliation, empiricism, ephemeral therapeutic fads or much-vaunted ultra scientific methods?

Reflections such as these must inevitably temper any unreasonable faith in the infallibility of our therapeutic specialty, at the same time encourage worthy endeavor to utilize the rich harvesting of the early toilers in the therapeutic field, carefully, yet honestly, winnowing the golden grain from the chaff, and by modern pharmacological investigations, supplement our knowledge of pure drug pathogeneses.

To render practically available the vast collection of drug pathogeneses, and place it within the ready access of the busy practitioner, Hahnemann ipse, ever on the alert for labor-saving devices, *rearranged* the symptomatology according to the natural *anatomical* order, and to this day, from its practical utility, has been almost universally adopted by most authors on materia medica, slightly modified by the personal bent of the collator. In this *regional* or *Hahnemannian scheme*, original provings were dissected and dismembered, thereby destroying the genesis and sequence of symptoms, but infinitely facilitating easy study and reference.

Subsequently, another aid found necessary to facilitate the selection of the indicated remedy, led to the inception of the *repertory* or *index of symptoms*. It has, ever since its introduction, been found a most useful and essential appendage to the homœopathic materia medica, by means of which we can readily discover almost any recorded symptom of any proven or even clinically attested drug.

Thence, a legion of therapeutic and clinical indexes, keys, guides, from the most unpretentious vademecums, well intentioned, but at times misleading, to those scholarly tomes, fitting tributes to the matchless skill and patience of Jahr, Boenninghausen, Allen, Clark, Kent.

Only the ever-bustling practitioner, fretted by the ceaseless stress and strain of his wide range of daily duties, can fully realize the urgent need of some such guide, in his perforce hasty search of a curative remedy. Who has not been baffled, yes, humiliated, at most inopportune times, by the vixenish trickery of a temporary amnesia as to a remedy possessing this or that unique symptom or complex, or, after having prescribed and departed from the sick room, as an afterthought on the stairs—"esprit de escalier," wishes fervently he had done otherwise, and earnestly hopes that all will be well?

The secret of successful use of the repertory is to become thoroughly acquainted with any of the dependable ones, and by persistent and constant reference to it, familiarizing oneself with its peculiar and involved arrangement. Naturally, the broader the general symptom knowledge, the easier of access, and the more profitable the returns from such use. The repertory may be compared to a radiograph, which reveals outlines, shadows and relations, the accurate interpretation of



which depends on the astute perception, specialized knowledge and critical skill of the reader.

Permit me to remark that it is not within the province of this paper to impart to you any information as to "*how to study*" the repertory, which in its very essence is a detailed task, evolved by the personal training, experience and dexterity of each user of the work, and cannot be taught, but must be mastered by a life's apprenticeship. No more than a system of musical correspondence can teach skilled instrumental technique. Rather, simply some suggestions, "*How to approach*" the use of a pocket repertory, so that in a given case of disease, what symptomatic facts shall we gather homœopathically, from the diverse morbid assemblage, to *totalize* our case for condensing and refining through the medium of the repertory.

Complicated, obscurely involved *chronic* cases should not be essayed a solution by reference to a fragmentary work, such as a condensed pocket repertory, must necessarily prove to be. They demand deep study and analysis. But in that vast array of *acute* cases daily treated by the physician, where the selection of a suitable *simile* may produce at least temporary beneficial results, recourse to the pocket repertory is surely more commendable than patent flirtations with extra homœopathic or alien therapeutic measures.

Repeated personal failure in early practice, based on a senseless *mechanical symptom matching*, just as apt to miss as hit, has fully convinced me that in our quest of a *curative* remedy, the sole guide, as taught by Hahnemann, must ever be, "*the totality of subjective and objective findings.*" In view of the tremendous advance of general and special diagnostic procedures, a *modern* Hahnemannian totality has expanded so inordinately as to be wholly disproportionate with our present *imperfect* symptomatology, and, therefore, too elaborate for practical use. The *complete* totality is ever the basis for an *ideal* similitum; a *practical* totality, that of a *desirable* simile. Let the repertorist seek to construct a totality of intrinsic worth and quality, and not one of mere numerical greatness. The ampler the reserve fund of symptom knowledge of drug and disease of the physician, the surer his discriminative power and selective acumen in constructing his totality. As Boenninghausen says, "The more the physician knows, the less he

has to look for, and finally comes to use a repertory only here and there to help his memory."

Avoid incorporating those *general* or *absolute* symptoms readily noted in *all* patients suffering from the *same* disease and though of undisputable diagnostic value (being the pathognomonic symptoms of the disease), yet are practically negligible for prescriptive purposes. This group includes such symptoms as malaise, anorexia, headache, backache, sore throat, fever, rash. But such symptoms may become enriched by some modifying condition (modality) or concomitant, and so attain the dignity of useful or characteristic symptoms. Thus sore throat, < warm or hot drinks, lachesis; phyt. Ameliorated by same, Lycopodium, alumina, arsenic. Backache, > voiding red sandy urine. Lycopodium; ameliorated by continued motion or lying on something hard. Rhus tox. Headache, > copious, clear urine. Gels., ign., phos. acid.; ameliorated by eating, anac., lith. carb., psor. Headache, > pressure and wrapping up warmly, mag. mur., silica, strout. carb. Headache, with nausea, vertigo, least motion, even on first opening eyes in morning, bry. Cough, > covering head with bedcovers, hepar., rhus. tox., rumex. Backache, with tenesmus, > dysenteric stools, nux vom.; unrelieved merc.

If in health, dominant *mental* and *moral* traits stamp the impress of what Goethe terms, "The most precious mede of mortals—*personality*," why should their presence in disease not exercise a similar sway? In truth, they do, and ever since Hahnemann intoned their primacy "gemüths symptome" have preponderated over such as are merely objective and physical. Often a scarcely discernible dispositional change foreshadows the oncoming disease, even preceding organic change, and likewise a *mental improvement* may be the harbinger or earliest evidence of a curative remedy. Who has not frequently been in a remedial quandary, not even a hazy simile tangible, when, lo, some cardinal clinching mental phase looms big and unique, and like sun-dispersed mist clarifies the path to an individualizing remedy?

Who, in extremis, has not grappled to his aid such sheet anchors as—the anxietas, distressed, restlessness of *acon.*; *actea rac.*; *ars.*; *bism.*; *ign.*; *lach.*; *phos.*; *rhus. tox.*; *ver. alb.* The apathetic stolid, indifference of *actea rac.*; *apis.*; *bapt.*; *cinch.*; *gels.*; *helleb.*; *ign.*; *phos. ac.*; *picr. sep.*; *staph.*

The furors, delirious ravings of *bell.*; *canth.*; *cic.*; *hyos.*;

solan. nig.; *stram.*; *ver. alb.* The hysterical instability and hyperesthesia of ambra.; *actea rac.*; *asaf.*; *cocc.*; *ign.*; *mosch.*; *nux mosch.*; *plat.*; *sumbul.*; *val.* The irascible, captious, disgruntlement of ant. crud.; *bry.*; *cham.*; *cina.*; *colch.*; *col.*; *nit. ac.*; *nux vom.*; *sep.*; *staph.* The lachrymose, melancholic, full of blues of *actea rac.*; *cycl. dig.*; *graph.*; *ign.*; *nat. mur.*; *plat.*; *puls. sep.*; *stam.* The suspicious mistrustfulness of *anac.*; *actea rac.*; *hyos.*; *lach.*; *nux vom.*; *staph.*

Valuable, indeed, are those *prominent*, *peculiar* and *uncommon* symptoms that *reflect* the patient's uniquely, *individual impress* upon the disease, and so attain the distinctive status of *characteristics*. Thus pre and postnatal tendencies exercise a formative influence, and their deliberate study opens a path of immense future possibilities for *eradivative* homœopathy.

Cases may present themselves devoid of any characteristic symptoms, and these prove a veritable *bete noir* to the most adept repertorist. For example, in children or the aged, where they are often absent, we may be justified in utilizing a *pathological similarity*, *e. g.*, the broncho pneumonia of ant. tart., or ferrum phos.; asthma of grindelia or ipecac; catalepsy of cannabis. ind.; tinnitus aurum of conchona; colic of colocynth or plumbum; gastro-enteritis of arsenic; epileptiform convulsions of hydrocyanic acid, etc. Upon this basis we can build from the patient's peculiar or unique symptoms a serviceable group.

Whereas, in chronic disease, the earliest or first symptoms are of prime value; in acute disease, *per contra*, the *late* symptoms being the most recent exhibition of the disease's activity are to be specially noted. These may open a vista of a second or succeeding remedy, which may continue or supplement the curative range of its predecessor. This brings into play *complementary* drug relations. Thus, aconite is followed by sulphur; *bry.* by alumina; *bell.* by calc. carb.; *cham.*; *hep.*; *silica*; *puls.* by *sil.*; *apis* by *nat. mur.*; *arnica* by *nat. sul.*

In acute diseases the physician ultimately acquires the intuitive use of his eyes, ears and touch, and learns to seize certain salient or definitive conditions quickly, that are known to correspond to certain remedies, and thereby eliminates much of the customary routine examination and investigation. This is notably so in *epidemics*, where direct, rapid and usually successful prescribing is the rule of action. During the prevalence



of epidemic diseases, *e. g.*, vernal and autumnal colds, influenza, exanthemata, diarrhoeas and pertussis, it is often the case that several remedies cover the field—the “genus epidemicus.” It is almost needless to enter into the detailed symptomatology, since epidemic remedies, when found (from the study of a series of cases) correspond to the *collective totality* or complete and composite picture of numerous cases and types of the epidemic disease; each individual case, presenting only one phase and aspect, in brief, a *partial* picture of the genuine epidemic. Thus the ravaging epidemic influenza of 1918-1919, encountered most valiant antagonists in a cohort of remedies, such as, aconite, ant. t.; ars.; bell.; bry.; crotalus; eup. erf.; gels.; lach.; phos., etc.; and again, proved statistically by an unprecedentedly low mortality, the vital superiority of homœopathic therapy.

As to the *quality* of the symptoms, be it said, that in their bald nudity, they count for naught, but when properly *perfected*, they stand forth as organic entities.

*Perfect* symptoms are composite in nature. Boenninghausen says: *Triad*, comprising (1) *location. i. e.*, elective affinity, or specific seat of action. Bell.; hyosc.; stramon., the brain. Actea rac.; secale; viburnum opulus, the uterus. Baptista, the Peyer's patches, intestinal glands. Asclepias tub.; bry., the serous membranes. Kali bich.; phosphorus, the periosteum, tellurium, the tympanum. Arsenic, the skin, and mucous membranes. Rhus tox., the skin and fibrous tissues. Aloe, the liver, the portal and pelvic viscera. (2) *Sensation* or specific type of action. Burning of *anthracinum*, *arsenicum*, *cantharis*, *capsicum*, *phosphorus*, *sang.*; *sulphur*. Coldness of camphor, *carbo veg.*, *helod*; *menyanthes*, *tabacum*, *veratrum album*. Numbness of *acon.*; *agar.*; *cham.*; *cocc.*; *phos.*, *platium*, *rhus tox.* Stching pains of *asclepias t.*; *bryonia*; *kali carb.*; *ranunculus bulb.*; *scilla*. Stinging pains of *apis*, *theridion*. Aching, bruised pains, soreness of *arn.*; *baptisia*, *bellis*, *eupatorium perf.*; *gelsen.*; *hamam.*; *phytolacca*, *pyr.*; *rhus t.* Thirstlessness of *apis*, *gels.*; *nux moschata*, *pulsatilla*, *sabadilla*. All gone feeling of *abies can.*; *dig.*; *hydrastis*, *ignatia*, *lobelia infl.*; *sepia*, *sulphur*, *tabac*. (3) *Modality* or *aggravations* or *ameliorations*, which comprise the phenomena of time of day. Worse early morning, *aloe*, *ammon. carb.*; *kali c.*; *nux v.*; *podo.*; *rumex*, *sulphur*. Weather, worse wet exposure, *calc. c.*; *Dulc.*; *merc.*; *natrum s.*; *ranunc. b.*; *rhus tox.*; *tub*. *Side* of

body, worse left, *ceanothus*, *lachesis*, *lil. tigr.*; *merc. iod. rub.*; *spigelia*. Posture of body, worse lying on affected side, *hep.*; *iod.*; *kali c.*; *nux m.*; *phos.* Mental exertion, worse, *anacard.*; *arg. n.*; *cocc.*; *gels.*; *natrum c.*; *nux vomica*; *phos.*; *picric acid*, *sil.* Rest, relief from, *bry.*; *colch.*; *nux v.*; *phytolacca*, *ranum.* b. Motion, relief from, *capsic.*; *cycl.*; *fer. met.*; *helon.*; *pulsatilla*, *rhus tox*; *sep.* Eating, relief from, *anac.*; *chel.*; *ign.*; *iod.*; *lith. carb.*; *petrol.*; *psor.*

At times, the aggravation may be an *etiological* factor, and prove useful, *e. g.*, disturbances traceable to psychic depression, as grief, sorrow, worrying, *aur.*; *gels.*; *hyos.*; *ign.*; *natrum m.*; *phos. ac.*; *staph.* Or, headache from gastro-enteric derangement, *ant. c.*; *bry.*; *carbo veg.*; *cinch.*; *nux v.*; *puls.* Diarrhoea from chilling, *acon.*; *arsen.*; *bry.*; *puls.*

The *modalities* embrace *all* the circumstances on which the development and appearance of the symptoms depend, and, therefore, are the true modifiers, precisioning the symptoms, and so conferring character upon them, and to my view, worthy of the highest rank.

Attending conditions, termed *concomitants*, offer a rich source of symptom building and help to perfect them perceptibly.

Perfect symptoms, though comparatively rare and broadly scattered, should always be diligently sought; for, remember, a few genuine compactly built symptoms, intrinsically outweigh a dozen vague, loose-jointed.

As an illustration of a perfect symptom we quote from Hahnemann's proving of *Nux Vom.* "Headache beginning some hours before dinner < after eating, then violent shooting pains in left temple, with nausea and very acid vomiting; all of which symptoms disappeared on lying down."

Or of certain pains of *pulsatilla* he says: "They are short-lasting, drawing tension, which always terminates in a darting analogous to tearing, somewhat as if a nerve were put upon the stretch and then let loose again suddenly, causing a painful jerk. Or feeling as of an internal ulcer."

When the available symptoms of the case have been collected and appropriately constructed, they are arranged separately in the order of their *relative* value, and studied both independently and interdependently and the process of *individualization* of the case instituted. Hahnemann says, "Individualization in the investigation of a case of disease demands on

the part of the physician, principally unbiased judgment and sound sense, attentive observation and fidelity in noting down the image of the disease." His first rule is, the characteristics of the patient must be similar to the characteristics of the drug.

The *tracing* or reference of the symptoms to their sources, *i. e.*, rubrics, headings, sub-headings under the various regional sections, cumulates a series of remedies, which are subject to the final process of "*winnowing*," embracing *comparison, differentiation, elimination*; ultimately leading to the selection of the indicated remedy, or more frequently, *several* more or less similar remedies (*similes*). The practicableness of our law of cure is happily demonstrated in the clinical fact that *several similes* (more or less corresponding remedies) may act in a curative plane, though less prompt, direct and radical than the much coveted *similimum*. Were it otherwise, and a *single* remedial solution or *similimum*, requisite in each case of disease, I apprehend that we of lesser selective powers would encounter as perplexing a problem as the modern seekers of a Simian Elixir of rejuvenescence.

Repeated exercise, diligent application and a vested fund of symptomatology will eventually cultivate an adeptness in drug selection that attains well nigh the accuracy and certitude of intuition. 'Tis the insight of the master artisan who grasps the soul of things!

Yet, despite all, "*errare humanum est*," the physician who respects veracity cannot disavow the frequent occurrence of depressing therapeutic failures so humbling to his professional vanity and self-assurance. Some of these failures arise from valiant but fruitless efforts to combat that gloomy cortege of hopeless, incurable diseases, aptly termed, "*opprobria*," or reproaches of medicine (now more efficiently treated by radio, electro and glandular therapy and modern surgery); others again are dependent on the manifest inadequacy of our therapeutic art or bungling, bigoted, errant methods of procedure; and some, alas, are palpable evidences of the caprices of that elusive, inherent *vivendi vis*.



**THE RADICAL CURE OF FEMORAL HERNIA BY THE INGUINAL ROUTE.**

BY

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(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 16, 1919.)

THE subject of the surgical treatment of hernia is always appropriate and in order. Probably more failures follow operation for the radical cure of hernia than for any other serious disease or defect. We may say that the operations for the radical cure of inguinal and umbilical herniæ are now practically standardized. For the cure of inguinal hernia the Bassini method is employed more frequently, probably, than any other, but from personal experience during the past two and a half years I wish to include the operation advised and practiced by the late Emil Beckman of the Mayo Clinic, whose method of treating inguinal hernia I believe to be superior to the Bassini method. The radical treatment of umbilical hernia is now practically established upon a firm basis and the majority of cases can be permanently cured by the Mayo method. At least up to the present time we have not been able to say the same for femoral hernia.

We must acknowledge that the number of different operative plans for the radical cure of femoral hernia is very much smaller than the number advocated for the radical cure of inguinal hernia. Indeed, the different methods of operating for the cure of femoral hernia may be summed up on the fingers of one hand. Only two principal methods are written or talked about and practiced, viz., the older Bassini method, and the purse-string operation more recently proposed by Harvey Cushing. The number of different methods advocated for the cure of inguinal hernia is legion. The truth of the matter is, the anatomical make-up of the inguinal canal permits a more substantial and secure closure of this canal; yet many of the different ways and means proposed to accomplish this have fallen by the wayside and to-day the Bassini operation and that of Beckman may be regarded as the survival of the fittest.

In order to bring about a radical cure of a femoral hernia, Poupart's ligament must be approximated or attached to the underlying horizontal ramus of the pubic bone, *i. e.*, to the pectineal fascia covering it. This latter structure is far from being substantial enough for us to expect Poupart's ligament which is, in one sense, a bridge extending across the femoral ring, to remain securely and permanently fixed to the underlying pectineal fascia, particularly where there is the pressure (the *vis a tergo*, if you please) of the abdominal viscera above and behind tending still further to separate these structures and precipitate a recurrence of the hernia. The delicate fascia covering the femoral vein forms the outer wall of the femoral ring and that is also weak and naturally lacks the supporting qualities which must be sought for and obtained to radically cure a condition which is so difficult to cure as a femoral hernia. The feature of the Bassini operation is the approximation by sutures of Poupart's ligament to the pectineal fascia, endeavoring thereby to permanently close the femoral ring. The falciform process of the fascia lata is tacked down to the pectineal fascia and to the pubic portion of the fascia lata. In the Cushing operation a purse-string suture of kangaroo tendon is introduced through Poupart's ligament, Gimbernat's ligament, the pectineal fascia and the fascia covering the femoral vein and thus closure of the ring is supposed to be effected. Here we attempt to approximate and fix in a position of displacement two more or less tense fibrous structures and two weak, flimsy structures, and in doing so always being fearful, and here sacrificing security for fear, of wounding the wall of the vein.

While femoral hernia is not as common as the inguinal variety, nevertheless it is frequent in both sexes, occurring oftener in the female than in the male. Femoral hernia is not only harder to cure by operative procedure but it is more liable to complications, such as strangulation, than the inguinal variety. Nor is it satisfactorily treated or retained by a truss. One should remember, too, that the Richter form of femoral hernia, where only one portion or side of the intestinal wall is herniated, and in many cases strangulated, may be quite difficult of diagnosis, inasmuch as an external, palpable tumor is not always present under the circumstances.

A better method of radical cure of femoral hernia has

been sadly needed, and unquestionably an invaluable improvement over the above mentioned operations is offered by the inguinal approach. It is less than five years ago that Deyarier, Moschcowitz, Lance and Didier contributed valuable articles of advice and experience on the cure of femoral hernia by the inguinal route. The consensus of opinion of these well-known authorities is that the inguinal route gives a more open field of operation. These are the days of open surgery; we have emerged from under the shadow of closed or hidden surgery, with its small wounds and fear of hemorrhage and sepsis. To the surgeon of the twentieth century there is no "crown of death," the corona mortis of the older operators, in an anomalous obturator artery coasting along the margin of Gimbernat's ligament. The surgeon of to-day does not (and will not) use a herniotome (an obsolete instrument) and pass it, out of sight, up the so-called femoral canal and divide the constricting ring, which is Gimbernat's ligament, in the dark.

By the inguinal route two substantial fibrous structures are approximated and secured under the guidance of the eye. These are Poupart's ligament and Cooper's ligament. The latter is a comparatively new ligament to both the anatomist and the surgeon, i. e., due recognition has never been accorded it until recently. Its existence was first emphasized by Sir Astley Cooper, and it was named after him, although the most casual reference, if any at all, is made to it in the text-books on anatomy.

1. The first step of the operation is making the incision through the skin and fascia, exactly the same as if operating for the cure of an inguinal hernia.

2. The second step consists in dividing the aponeurosis of the external oblique in the direction of its fibers, also as when operating for inguinal hernia.

3. By raising the upper flap of the external oblique aponeurosis, the conjoined internal oblique and transversalis are brought into view, and a retractor is slipped under these muscles and used to retract them upward. Another retractor is passed under the lower flap of the external oblique aponeurosis, which is drawn downward, bringing Poupart's ligament into full view. The round ligament or the spermatic cord is retracted upward. Good retraction gives a very free exposure and presents to view the transversalis fascia, a thin layer im-



mediately anterior to the peritoneum. It is nicked, divided bluntly along the line of the original incision and then picked up by retractors exactly as were the other structures. Good retraction brings the peritoneum into view and exposes the neck of the sac. The deep epigastric artery is usually encountered during this stage and may be drawn aside or, if it runs an anomalous course, divided between ligatures.

4. Open the peritoneum as it converges to form the sac. The hernial contents are now pulled up out of the sac, replaced in the peritoneal cavity, and held there by a gauze pack, if necessary. If the intestine or omentum is strangulated, it may be liberated with ease by cutting Gimbernat's ligament which forms the inner margin of the constricting ring. Gimbernat's ligament is in full view, therefore it is impossible to encounter uncontrollable hemorrhage from an anomalous obturator artery. If the contents are adherent, one of two things happens. (1) either the sac is not adherent to the tissues of the thigh (almost the invariable rule), in which case traction on the hernial contents pulls the entire sac out of its bed, converting the femoral into an inguinal hernia when the adhesions are conveniently dealt with, or (2) the sac is adherent to its bed, when the incision should be extended downward on the thigh, over the protrusion and the sac dissected free from its adhesions.

5. Introduce a dressing forceps into the sac to its lowest point, then close the forceps and withdraw upward. This everts the sac and converts the femoral into an inguinal hernia. The sac is now tied off by a ligature or by suture with ease and sufficiently high to guarantee absolutely against leaving a dimple, protrusion or any variety of potential hernia behind. If the sac does not evert easily it is adherent, and then must be dissected from its bed by retracting the lower skin flap or by incising downward, as just described.

6. Closure of the femoral ring. The ring is exposed by retracting the lower flap of the external oblique downward and outward and retracting the skin, upper flap of the external oblique, the tendon of the internal oblique and transversalis muscles and transversalis fascia upward and inward. When the parts are retracted one can palpate the horizontal ramus of the pubic bone and see it covered by a dense, tough, white, glistening fascial band. This is Cooper's ligament. With a

small, full-curved needle pass a kangaroo or chromic cat-gut suture through Cooper's ligament (deep enough to go down to the periosteum of the pubic bone) just internal to the iliac vein and then through the lower flap of the transversalis fascia and the edge of Poupart's ligament. Another suture is similarly placed internal to the first, and a third still further internally, if necessary. The most internal suture always picks up Gimbernat's ligament. When these sutures are tied they approximate Poupart's to Cooper's ligament and effectually close the hernial orifice.

7. Represents the ordinary closure of an inguinal hernia.

The several steps of this operation are rational and logical; to attack a femoral hernia by cutting down over the hernial protrusion, i. e., below Poupart's ligament, now seems to me to be illogical and decidedly wrong. Just think, too, under what greater advantages the gangrenous loop of intestine can be dealt with, possibly resected. Now, everything is spread out before the operator; formerly, the incision had to be carried upward across Poupart's ligament and often there was so much tension on the intestine and its mesentery that the success of the resection and anastomosis was jeopardized.

So far I have operated upon eight cases of femoral hernia by the inguinal route and from this experience, limited as it is, I believe that it is the ideal method. In none of my cases was I obliged to employ step number four, i. e., add a downward (femoral) incision to the original (inguinal) incision. In other words I was able to reduce the hernia easily and completely through the inguinal opening and also to evaginate the sac—reduce it, in other words, through one and the same wound. In two of my cases I had to deal with strangulation requiring resection and anastomosis, which step, frequently so difficult to perform when the old "femoral" incision is employed, was easily and successfully done via the inguinal route.

**SURGICAL EXPERIENCES WITH THE BRITISH EXPEDITIONARY FORCES.**

BY

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(Read before the Pennsylvania State Homœopathic Society, Sept. 17, 1919.)

IN the summer of 1917 the need for medical officers in the British army was acute, as earlier in the war medical students had entered the combatant forces, leaving little or no source of supply. Then, too, the mortality in the medical services had been quite high. In consequence, Col. Goodwin, who later became director general of medical services in both Britain and France, came to this country on a mission to urge our government to send medical officers to the aid of the British. I understand that he offered at that time to give those doctors, whom the U. S. might send, British commissions and British pay. This would have been to our advantage in regard to the commission, for our promotions would have come to us very much more quickly. However, we were fortunate to have our government do, what one British officer termed "the sporting thing," namely to give us U. S. commissions and pay, especially as to the pay for that was somewhat higher than the corresponding rank in the British army. As a result of Col. Goodwin's mission, nearly 1,000 of us individually in addition to the several base hospitals as units were handed over to the British.

So after a short course of lectures by Col. Goodwin at the Army Medical School in Washington, and after our inoculations and vaccinations had been completed, we were sent to Great Britain and distributed to the different commands. Some of us were sent to the southern command whose consulting surgeon was Mayo Robson. At Tidworth we were assigned to the surgical division under Col. Boyd Carpenter. There we stayed only a few days, mainly learning the necessary paper work and assisting in the wards and operating theatre. Incidentally we began to learn the differences in ways, manners and means. In spite of these differences, our aim was to fit in with as little friction as possible and do our work to the satisfaction of the officer commanding. From results and future testimonials, I believe most of us reached that goal.



In a few days most of us were sent to another part of Salisbury Plain—Lark Hill, made famous as the training ground for “Kitchner’s Mob.” Later in succession it was used for the same purpose by the Canadians, Australians and New Zealanders and at the time we were there by the new British recruits—young and old, mostly men who formerly had been rejected. Nearby was the famous, pre-historic relic, Stonehenge, and only a few miles distant the beautiful Cathedral of Salisbury. Here we spent a couple of months in training of army routine before going to France. During that time I was assigned to the surgical section under a former assistant of Sir Wm. MacEwen of Glasgow. The surgical work was very much like that of a civilian hospital in that we had no convoys of wounded. Many times we prepared to receive convoys that never came.

In consequence of the type of men for whom we cared, namely defective in one way or another, or as they were termed “category men,” that is not in Class I; our work was largely of a reconstructive type. Our aim in operating was only to make the man fit for a higher category and in so doing to increase the man-power of the army, which was so essential at that time, before our own troops had commenced to arrive in any great numbers. I believe hernia topped the list of all operations. There the Bassini was in high favor. In addition, of course, we had appendicitis, infections and plenty of fractures, as in addition to the general training camps, there were nearby several aerodromes.

The anesthetic in use and favored by the British was the A.C.E. mixture (alcohol, chloroform and ether in proportions 1, 2 and 3). Ether was not at all popular and, even where indicated, not at all satisfactory. This fact may be due to one of three causes or possibly all three combined, namely the quality of ether supplied, the conditions of climate and the special type of patient, who was given to the excessive smoking of cigarettes. In spite of the fact that patients were taken from the operating theatre into unheated corridors or even out of doors to the poorly heated wards, the pulmonary complications were rare. In fact no cases of pneumonia developed and only two of bronchitis, both of which evidenced *rales* before operation. It is very difficult to procure nitrous oxide and in consequence it was reserved for the most severe

cases. Pure chloroform was a favorite, especially among those of the Scotch School, and was peculiarly adapted to the setting of fractures and the reduction of dislocations in muscular patients, or to patients whose respiratory system was diseased.

In France the necessity of rapidly getting large numbers of wounded ready for the surgeon led to the use of ethyl chloride, nitrous oxide or pure chloroform in the preliminary stage. These were highly efficacious because of the fact that the wounded were usually excited and in consequence resistant, shouting and struggling during induction. The use of the Shipway apparatus was quite universal and of advantage in several respects. It allowed the use of oxygen through ether or chloroform or both, giving via a thermos bottle a warmed vapor. These two factors of oxygen and warmth made chloroform all the more safe. It was superior to the drop method in that it prevented the atmosphere of the operating theatre from becoming laden with ether. Spinal anesthesia was used for a few amputations, where the patients were in extremely severe condition. Local anesthesia was employed frequently in chest wounds. A state of analgesia was induced and maintained for minor operations by a mixture termed "Souise". It consisted of ethyl chloride, chloroform and ether in proportion 1, 2 and 8. It was administered by saturating with the mixture a piece of flannel, which in turn was placed in a mask which fitted over the patient's face and was closed by a draw-string. The eyes of the patient were, of course, protected. A patient was usually in a state of analgesia in less than four minutes. This state may be maintained several minutes and upon removal of the mask, in a very few seconds the patient will be awake.

The hospital, to which we were attached in France, had about 2,600 beds and there were treated all cases except contagious and venereal, which were cared for in hospitals nearby. Our patients included those from the British Isles, Canada, Australia, New Zealand, China, India and Africa, as well as Americans, French and Belgian civilians and German prisoners. During the influenza epidemic our work was largely medical and just as little surgery was performed as possible. How I did wish for our method of treatment, and how many times I saw the pictures of belladonna, bryonia, arsenicum

and the rest. All drugs seemed useless and in many cases worse than useless, as for example aspirine, phenacetin and the like. I did have the satisfaction of treating the civilians, whom I was sent to attend, with our own remedies and thanks to them without any mortality. When we were having so many serious pneumonias and such a high mortality in the hospital, I can well remember the D.D.M.S. of that region saying:—"These cases must be treated symptomatically. If you relieve the symptoms, it gives nature a chance to cure. We are a d—d ignorant lot and our whole method of treatment must be rotten. I don't care that for routine. We must individualize." Needless to say I agreed with him, for is not that the exact teaching of the "Organon"? I doubt, however, that he had ever read or even would consider studying that particular book.

Among the surgeons attached to the hospital were some very capable Canadians. Col. Bruce of Toronto, who visited this country in 1918 as representative of the R.A.M.C. in France with Sir A. Laue, and Sir W. MacKenzie on a medical mission, was our consulting surgeon. He was particularly good to us Yanks and by his influence we got some very good work. As we cared for a large base as well as troops from the front, here too part of our practice was of a civilian type. However instead of hernia, here hemorrhoids topped the list. And as Bassini was the favorite for hernia, so the clamp and suture was the operation of choice in hemorrhoids. There was also considerable eye, ear, nose and throat work. The guillotine was the favored instrument in tonsillectomy and was used with a great amount of skill and speed by its devotees.

On the other hand, many times we did only military or war surgery and, at the time of a big push, we even acted as a C.C.S., receiving patients with their field dressings still on. Of necessity this work was coarse and crude in comparison with the fineness and delicacy of civil technique, for many times we worked night and day with hundreds waiting their turn. Our efforts were mainly two: first, to operate the more serious cases and evacuate the patient as soon as advisable; second, to restore the slightly wounded to full activity and send them as soon as possible back to their regiment and duty. In spite of the fact that so many came down with their original field dressing, we had very little gas gangrene from this source, but from the C.C.S., where wounds had been sutured, in spite



of repeated orders to the contrary, we had many a serious and often a fatal case. Except for wounds of the face we seldom, if ever, performed primary suture. Perforating wounds, caused by machine-gun or rifle bullets without marked destruction of tissue were treated conservatively and seldom needed surgical interference. The same also usually applied to penetrating wounds made by small bits of shrapnel and to the same type of wounds caused by bullets, for the damage to tissues by the operation outweighed the advantages of removal. If the foreign body was superficial or lay near a large vessel or in the belly of a muscle, it was then removed. On the other hand, wounds, especially of the soft parts, caused by high explosive were usually badly torn. As a result the tissues were greatly devitalized and formed an almost perfect culture medium for the virulent bacteria introduced via the shell fragment or clothing from the soil, which had for years been so intensively fertilized. These wounds were excised and the foreign body and devitalized tissue removed in order to prevent the extension of infection. Frequently the greater part of the gluteal muscles or all the hamstring muscles or both had to be removed to prevent the production of the gas organisms. Although apparently extremely radical, this procedure was in reality conservative, as it was a life-saver and hastened convalescence.

In fractures caused by bullets with little destruction of tissue, the conservative method was again employed. In those with extensive destruction and many loose fragments of bone, excision and removal of foreign bodies and loose bone was practiced. In the infected fractures, the method was first to wash out the wound with ensol. Then, when the infection subsided markedly, irrigations of a quafflavine 1-3,000 were used to promote granulations. Where the bacterial count was small, i. e., 1 bacterium to 1 or 2 fields, the wound was "bipped" (a paste of bismuth iodoform, and paraffin) and sutured. Daily stereoscopic roentgenograms were taken to note the decrease in the shadow of the bismuth and the growth of granulation. In rare instances, iodoform poisoning resulted. This was avoided by using just enough "bipp" to place between the ununited fragments and leaving the rest of the wound clean. Iodoform was present in the urine often, when the area was large without the symptoms of poisoning.

These experiences will no doubt be of value and applicable with modifications to the traumatic surgery of civil life.

## GLEANINGS

### MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

**X-RAY DIAGNOSIS OF EARLY TUBERCULOUS COLITIS.**—According to Brown and Sampson, of the Trudeau Sanatorium, in the early or latent stages of tuberculous colitis the clinical picture contributes little to diagnosis. However, certain X-ray shadows taken 6, 18, and 24 hours after a barium meal show definitely the presence of colonic ulceration, though their absence does not exclude it. The X-ray picture also shows hypermotility and spasm, or filling defects, and such a picture in a patient with pulmonary tuberculosis should lead to a definite diagnosis of colonic tuberculosis. The condition is far more frequent than has been hitherto taught, and must be excluded in all advanced cases as well as all early cases with abdominal symptoms, before submitting them to radical treatment. No examination of a patient with pulmonary tuberculosis can be considered complete without an X-ray study of the intestines.—*American Review of Tuberculosis*, 1920, Vol. III, No. 11.

**OCCULT TUBERCULOSIS.**—A large group of patients suffer symptoms from a tuberculous infection which is non-progressive. The symptoms are due to a subtle intoxication which undermines the functional powers and co-ordination of all vital tissues. This condition Sewall of Denver terms "occult tuberculosis." The patients as a rule are not definitely sick. There is a general functional insufficiency with lack of staying power that is brought out by slight physical strain. Neuralgic pains, headache, dizziness, undue fatigue, and nervousness are common symptoms. In women, menstruation is apt to be scanty or is frequently missed. The temperature is usually not elevated but may rise slightly after exercise. The lungs are rarely suspected, but they give auscultatory and X-ray evidences of slight sclerosis involving especially the hilum lymph nodes and the upper bronchial radiations. The symptoms may often be traced to circulatory or hormonal insufficiency. Many of these patients have probably been classified under the title "effort syndrome" or "neuro-circulatory asthenia." The most valuable objective sign of occult tuberculosis is the reaction of the blood pressure to slight strain such as changing from the supine to the erect position. Most of these cases have vascular hypotension, but the most significant feature is an abnormal lowering of pulse pressure and its tendency to progressive subsidence when the erect posture is assumed. This may be due to inordinate fall of systolic or to rise of diastolic pressure in the upright as compared with the recumbent position. This pressure change is not specific of occult tuberculosis but after exclusion of "focal infection," it should suggest this condition and lead to the application of diagnostic methods, especially X-ray photography.—*American Review of Tuberculosis*, 1920, Vol. III, No. 11.

**POSTURAL TREATMENT OF TUBERCULOSIS.**—Dr. W. F. R. Phillips reminds us that the erect posture causes the blood to accumulate in the more dependent

portions of the great vascular reservoirs of the body and suggests that the fact that pulmonary tuberculosis is always apical in the beginning means that the orthograde posture introduces changes in the hydrostatics and hydrodynamics of the pulmonary circulation which favor tuberculous infection.

In the course of an article of recent issue in the *Medical Record*, Dr. Phillips points out that recumbent rest benefits the diseased apical regions because they become absolutely more hyperemic, a large part of the blood from the previously over-filled and larger lower lobes being returned to them by hydrostatic pressure; moreover, whatever offensive and defensive properties may be present in the blood are brought into action at the seat of the disease. As long as recumbency is maintained, he remarks, the therapeutic effects of these properties is at a maximum, and is equal or superior to the power of the invading germs, stay or cure the disease, as the case may be.—*The Medical Times*, January, 1920.

**OCCUPATIONAL ULCERS.**—Two new conditions have been made notifiable under the Factory and Workshop act of 1901. One of these is the epitheliomatous ulceration due to tar, pitch, bitumen, mineral oil, paraffin, or any compound, product or residue of any of these substances; and the other is chrome ulceration due to chronic acid or bichromate of potassium, sodium or ammonium or any of the preparations of these substances. In industrial employment, ulceration of the skin is not infrequently set up by the substances handled. Under appropriate treatment, at no matter what age, such ulceration usually heals quickly, and should it recur will again heal with rest and treatment. In the cases of those handling tar and similar substances, however, especially when the workers are over 35 years of age, and have worked for many years at a particular operation, the ulceration following on the skin irritation set up may not heal, but spread over a larger surface. This form of ulceration, which occurs with relative frequency on the scrotum, is then to be regarded as epitheliomatous, and is to be notified as such to the Chief of Inspector of Factories at the Home Office. When chrome compounds and their solutions remain in contact with the broken skin and sometimes even with a very sensitive skin in the absence of a broken surface, they give rise either to a general eczematous ulceration or a circumscribed ulcer known as a "chrome hole." Both of these conditions when definitely ulcerative are now notifiable. Recurring attacks of either epitheliomatous or chrome ulceration should also be reported when a different part of the body is attacked.—*London Lancet*, January 3, 1920.

**X-RAY STUDIES OF THE SEMINAL VESICLES AND VASA DEFERENTIA AFTER INJECTION OF THE EJACULATORY DUCTS WITH THORIUM.**—Young and Waters have made use of the above method for the study of disease of the seminal vesicles, and present the following conclusions: The method seems applicable and helpful for diagnosis and treatment under the following circumstances: (1.) To determine the patency of the ejaculatory duct or vas in cases of sterility when epididymo-vasotomy is contemplated. (2.) To determine whether stricture of the ejaculatory duct or vas or of the outlet of the seminal vesicle is present. (3.) To disclose the condition of the ampullæ of vasa or seminal vesicles in inflammatory or tuberculous conditions. (4.) To show the condition of the seminal tract in studies to determine the cause of vague pain in the region of the prostate, vesicles or bladder. Other uses of this method will, be forthcoming.—*Johns Hopkins Bulletin*, January, 1920.



EFFECT OF PYLORIC OBSTRUCTION IN RELATION TO GASTRIC TETANY.—McCallum, Lintz and Vermilye have investigated this subject and have presented the following conclusions: When the pylorus is obstructed and the gastric juice with its hydrochloric acid is constantly removed, there ensues a decrease of the chlorine of the plasma. There is a constant increase in the alkali reserve which becomes extreme.

The electrical excitability of the nerves is in general heightened and there are spontaneous twitchings and in most cases violent convulsions which lead to death.

All this can be prevented by constantly furnishing a large supply of chlorides. It is less easy to cure the condition by the administration of chlorides.

The convulsive movements are not exactly like the twitchings of the tetany of para thyroidectomy in which we have found no heightened alkali reserve, but they can be produced by the injection of sodium carbonate or bicarbonate. Since these convulsions can be stopped or prevented by sodium chloride, it remains a problem as to what becomes of the excessive base sodium, and as to the specific need of the sodium ion. Further experiments are contemplated to settle this point.—*Johns Hopkins Bulletin*, January, 1920.

MENINGITIS TREATED BY INTRATHECAL INJECTIONS OF THE PATIENT'S BLOOD SERUM.—Waterhouse reports a case thus treated. The technique followed consisted in the removal of 50 c. c. of blood from the patient's veins. This was allowed to stand over night in a bottle in ice-cold water. Twenty c. c. of the resulting serum, after being warmed by placing the container in warm water, were then injected slowly into the arachnoid space by lumbar puncture after removal of the same quantity of cerebro-spinal fluid. This procedure was repeated on the three following days; only 12 c. c. of serum were injected each day, as the cerebro-spinal fluid was under less tension, and no more could be conveniently abstracted.

This line of treatment cannot be called altogether new, as McKenzie and Martin in 1908 reported 20 cases of meningitis treated by intrathecal injections of the patient's own serum or of serum from other patients convalescent from the disease. Of these cases four were chronic and all died. Of the acute, 10 recovered, 6 died.—*British Medical Journal*, January 10, 1920.

DIAGNOSIS OF DIVERTICULITIS.—Maxwell Telling, in an address before the Royal Academy of Medicine, reviewed the many symptom syndromes and secondary processes accompanying diverticulitis, and remarks concerning its diagnosis as follows: "The diagnosis can only be made after a careful consideration of all the facts in the case. Inflammatory trouble in the left lower quadrant in a person of middle or advanced age, carries with it a strong *prima facie* possibility of a diverticulitis being the cause, but beyond this, exact diagnosis is often difficult, and all special aids to diagnosis have to be requisitioned. These include (1) the sigmoidoscope, which has been disappointing in the main in this condition, though perhaps some may have had a favorable experience; (2) the cystoscope, which has been of particular value in a small number of cases; and (3) examination by the X-ray. This last procedure holds out most promise, and has been greatly developed the last few years. As may be expected, the technique is not of the easiest, and there are many fallacies in the appearances noted, but there is no doubt of the general diagnostic value especially in the differentiation from malignancy.

"The general data differentiating diverticulitis and malignancy are the following: 1. The absence of the shadows of malignancy from the general picture. 2. Tendency to obesity and maintenance of good nutrition generally. 3. Long history of attacks of abdominal pain in the left lower quadrant. 4. History of tumor formation with subsequent disappearance. 5. Absence of blood (visible to the naked eye) in stools over a prolonged period. 6. Presence of a vesical fistula in which malignancy can be excluded by cystoscopy. 7. Negative sigmoidoscopy as regards malignant disease. 8. X-ray demonstration of diverticula. 9. Pyrexial attacks. 10. Examination of the blood, the presence of neutrophilic leucocytosis, and the absence of the specific nuclear changes characteristic of cancer."—*British Medical Journal*, January 10, 1920.

**SYPHILIS OF THE BLADDER.**—Loyd Thompson reviews the literature of the subject and makes the following remarks concerning the incidence of syphilis of the bladder. Syphilis of the bladder has been considered by most medical men as a rare condition, and certainly, if the literature on the subject is to be considered as an indication of its frequency, such an opinion is justifiable. Only 84 cases, including the present one, purporting to be syphilis of the bladder have been found in a most exhaustive study of the literature, and for various reasons stated above, in these 84 cases the evidence in 26 is not considered sufficient to justify the diagnosis of vesical lues. This leaves but 58 undoubted cases. However, it is not believed that this represents the true incidence of syphilis of the bladder and the author feels very sure that if the condition were more frequently looked for it would be more frequently found. He ventures the opinion that if the bladder mucosa of every case of syphilis seen in the canthem stage were examined cystoscopically, in a large percentage involvement of this viscus would be observed. However, the present paper has to deal more particularly with syphilis of the bladder which produces symptoms and it is thought that if the possibility of lues were more frequently kept in mind by the urologist when treating some of the obstinate cystitides, the *Spirocheta pallidum* would more often be recognized as the etiologic factor.—*American Journal of Syphilis*, January, 1920.

**PATHOLOGIC STUDY OF THE LUNGS IN SYPHILIS.**—Pulmonary syphilis still remains today a doubtful and little explored field for the medical practitioner. Nevertheless, clinical diagnoses of syphilis of the lungs are much more frequently made than they are given the confirmation at the autopsy table. In view of the apparent increasing interest among clinicians as to the frequency of involvement of the lungs in syphilis, it is of great importance to attack this problem from the standpoint of the new pathologic criteria set up by such investigators as Warthin, Fordyce, and others. Carrera makes an attempt to cover up this gap in our literature. He has made an extensive review of the literature pertaining to the subject and besides has undertaken a pathological study in Warthin's laboratory. In conclusion he says: "The diagnosis of pulmonary syphilis must be made microscopically. The lungs of syphilitics show an incidence of fibrosis comparable with that observed in other organs of the same cases. They show also a high percentage of pulmonary pathologic conditions, in part at least, referable to the coincident myocardial affection. A certain number of cases (here 12 out of 152) present a specific syphilitic pathology of clinical importance, in the form of gumma, fibrosis, peribronchitis and arteritis. To what extent the high incidence of

fibrosis of the lungs is due to syphilis alone cannot be decided now, but it is probable that the lung is not exempt from involvement in the mild inflammatory process caused by syphilis in other organs, and which lead eventually to fibrosis." In his summary he remarks that the heart and aorta in every case showed typical active infiltrations. The great majority showed active lesions in the pancreas, adrenals and liver, and those cases in which the central nervous system was examined showed a high incidence of syphilitic lesions. Notwithstanding the fact that the author failed to find actual syphilitic lesions in the lungs, he has gathered from this that many other lungs may have been syphilitic, but the specific active changes were not found, and it is only upon these that a positive diagnosis can be made. He remarks that it seems most probable that the lungs are involved in the mild general infection of syphilis to about the same degree that the other organs and tissues are. —*The American Journal of Syphilis*, January, 1920.

#### PATHOLOGY

Conducted by JNO. G. WURTZ, M. D.

THE ACTIVITY OF LUNG EXTRACT, AS COMPARED TO EXTRACTS OF OTHER TISSUES, IN INDUCING COAGULATION OF THE BLOOD.—While it has long been known that tissue extracts hasten the coagulation of blood, Mills (*Jour. Bio. Chem.*, December 1919, p. 425) found that lung tissue was most active in this respect, being from two to thirty times as strong as other tissues in accelerating coagulation. Kidney extract came second, then heart, brain, spleen, thymus, testes and skin in the order named. Lung tissue, the author suggests, offers a possible source for the preparation of a strong hemostatic. The strong coagulation activity of lung and kidney tissues and to a lesser degree skin, suggests to the author the possibility of a protective mechanism against hemorrhage.

CONTROL OF DIPHTHERIA BY CULTURES OF THE NOSES AND THROATS OF SCHOOL CHILDREN.—Dr. Gloyne, as a result of his experience as Health Commissioner of Kansas City, Kansas, reaches these conclusions:

1. The swabbing of the throats of the children should be a measure adopted at the outbreak of a single case of diphtheria in a school.
2. The quarantine of carriers is as essential as is the quarantine of those suffering from diphtheria, in the controlling of an epidemic of diphtheria.
3. Two negative cultures should be required as the minimum from all children who have had a positive culture. A negative culture means something, but does not have the significance that a positive culture has.
4. Antitoxin has a very definite place in giving immunity against diphtheria, but it does not kill the diphtheria bacillus; so those who have had diphtheria may continue to be carriers for an indefinite time, if great care is not taken in getting at least two negative cultures from them.
5. Carriers usually clear up entirely without the use of antitoxin.—*Journal of the American Medical Association*, January 10, 1920.

CRESCENTIC BODIES IN AESTIVO-AUTUMNAL MALARIA; THEIR MIGRATION AND ATTACHMENT TO THE SURFACE OF THE RED CORPUSCLES.—Lawson (*Jour. Exp. Med.*, February, 1920, p. 201) in a well illustrated article, gives evidence that malaria plasmodia are not within the red corpuscles, as generally



believed, but attached to their surfaces. She claims that the plasmodia have the ability and do migrate from cell to cell, as shown by the amount of pigment in the organisms and their attachment to well filled red cells. She describes nodule-like projections on the red corpuscles to which the migrating plasmodia attach themselves. This "hemoglobin mound" is sooner decolorized by the action of the plasmodium than is the body of the cell; hence is seen with some difficulty. She mentions the findings of former observers to support her view.

**THE EARLY DIAGNOSIS OF TYPHOID AND PARATYPHOID INFECTIONS.**—Goeckel (*Jour. Lab. and Clin. Med.*, January, 1920, p. 255) cites three cases showing that typhoid and paratyphoid bacilli may be found in the urine of patients with these infections, before the Widal is positive. Urine collected aseptically is centrifuged and the bacteria present, according to the writer, subjected to the action of immune serum. Identification can be made in less time than by blood culture and a diagnosis made before the usual signs of typhoid and paratyphoid appear in the blood.

**THE IMPORTANCE OF BIOLOGIC CLASSIFICATION IN EPIDEMIOLOGY.**—Havens (*Jour. Lab. and Clin. Med.*, January, 1920, p. 229) points out the importance of biologic classification of bacteria. Many organisms—for example, pneumococci, streptococci and meningococci—have morphological and cultural characteristics common to each class, but biologically differ. Antisera are highly specific and while one group of a certain organism is affected by the serum, other groups are not. Repeated attacks of pneumonia may be due to subsequent infection with pneumococci of an immunological type different from those causing the earlier attacks. Havens cites instances showing how antisera failed therapeutically because the organisms causing the diseases were of a different biologic reaction than those from which the sera were prepared. Should all pathogenic organisms be studied biologically the ones causing an epidemic could be readily recognized and more efficacious antisera be prepared.

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## DERMATOLOGY.

Conducted by RALPH BERNSTEIN, M. D.

**ELECTRIC TREATMENT OF HERPES ZOSTER.**—Servetti reports two cases of herpes zoster in which prompt attenuation of the pain and disappearance of the eruption occurred following applications of the galvanic current to the region. The positive electrode was placed on the vesicles of the eruption and the negative electrode over the emerging point of the posterior roots of the fourth and fifth intercostal nerves of the right side, increasing from ten to twenty milliamperes, the sitting lasting from twenty-five to thirty minutes daily. The pain was relieved by the first sitting, and the cure was complete by the fifth.—*Journ. Amer. Med. Association.*

**TREATMENT OF BURNS.**—Hengerer outlines a treatment for cases of severe burn which he claims has saved patients with over one-half of the body burned, and which lessens the horrible deformities and disfiguration which is so often seen as the result of severe burns.

In every case of severe burn he immediately gives a full dose of morphin. Then he covers the damaged area with a clean towel or absorbent cotton,

and after getting the patient to the hospital, administers an anaesthetic and removes the damaged tissue by scrubbing the burned area with ordinary hand brushes until the surface appears to be covered with normal tissue; the object of the scrubbing being to remove all of the destroyed tissue. It is advisable, according to Hengerer, to have the scrubbing done as quickly after the burn has occurred as possible, but the length of time is not necessarily a contraindication, as he claims to have scrubbed burns three days after their occurrence, with good results. In the operation of scrubbing, brushes are changed frequently and aspesis should be employed as much as possible. After the scrubbing the wound is then dressed with a thick covering of petrolatum on gauze on which a small amount of bismuth iodid is sprinkled, or the wound may be covered with wax. The dressings, according to Hengerer, are bearable and often painless, and the time of convalescence is greatly reduced. He terms this the surgical treatment of burns.—*Jour. Amer. Med. Association.*

TRANSMISSION OF LEPROSY TO A MONKEY.—Development of nodular granulomatous lesions following inoculation of a monkey with leprous material is reported by Bradley. The material for inoculation was obtained from a non-ulcerated lesion on the eyebrow of a leper. Sixty days after the inoculation the disease made its appearance, and smear preparations made from three of the lesions showed leprosy bacilli in each one. The monkey lived but a few days after the appearance of the lesions and then died. A post-mortem examination resulted in lepra bacilli being found in the axillary and inguinal glands, and also in the spleen.—*Jour. Amer. Med. Association.*

BARLEY MITE ERUPTION.—An eruption, confluent in character, which was traced to an acarus of the pediculoides group, made its appearance upon sixty-three men engaged in unloading a cargo of barley whose point of origin was the near East. This eruption was first noticed two or three hours after work had commenced. It yielded to treatment for scabies. It is reported that six similar epidemics have been recorded at Havre in the last nine years. Sulphur fumigation of the hold of the vessel, and douches, with change of clothing for the workers should be included in the preventive measures which may be used.—*Journ. Amer. Med. Association.*

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## SURGERY

Conducted by J. DEAN ELLIOTT, M.D.

A ROENTGEN-RAY SIGN OF PERINEPHRITIC ABSCESS.—Fussel and Pan-coast report the finding of fluid in 2 cases of left-sided, perinephritic abscess. The second case was very obscure and it was only upon the fluoro copic finding that a correct diagnosis was made. It was obtained by placing the patient upright in the fluoroscope, grasping the shoulders and moving the patient's body quickly two or three times from side to side. A distinct wave in the fluid was seen in the fluoroscopic picture. The first case contained a huge sac of pus within the capsule of the kidney. In the second, the lower half of the kidney was firmly bound down, but an abscess, containing approximately 200 to 300 c. c. of pus, surrounded the upper pole.

Of necessity, pus about the right kidney will not be expected to give this sign, as the liver intervenes between the kidney and the diaphragm.

So far as the authors know no such observations of collections of pus between the liver and the diaphragm have been made, but they sincerely hope other observers will search for this sign.—*The American Journal of the Medical Sciences*, January, 1920.

COEXISTENT DISEASE OF THE APPENDIX AND PELVIC ORGANS.—Child (*Amer. Jour. Obst.*, 1919, lxxx, 31) has made an analytical study of a large series of cases of appendiceal and pelvic infections in women with the following general conclusions. When the infection is primarily in the appendix it is unusual to find any extensive pathological changes in the pelvic organs unless the appendix lies in the pelvis and is suppurating, in which case pus may gain access to the tube lumen or involve the ovary. Where the primary infection is in the uterine adnexa of the right side the appendix is frequently affected and should always be removed with the tube and ovary. In 746 cases studied, the appendix was removed 339 times. It was pathological 244 times, a percentage of 32.57. The percentage was much higher in the cases of primary pelvic infection, averaging 46.70. In the purely right-sided pelvic infections the appendix was pathological in 66.66 per cent. of cases, while where infection was limited to the left side of the pelvis the percentage dropped to 18.42.

NOTES ON VESICAL DIVERTICULA.—Rathbun (*Surg., Gyn. and Obstet.*, 1919, xxix, 28) states that in his opinion all true diverticula are congenital. He refers to a condition frequently seen in hypertrophied bladders as the result of some obstructive lesion in the prostate or urethra, but states that this does not constitute a real diverticulum, and that its treatment should be that of the underlying condition. In the absence of cystitis with foul urine, the symptoms of vesical diverticula are mild. Most patients are not seen, however, until severe cystitis has developed. They usually state that after having emptied the bladder, they are able to pass another considerable quantity merely by changing their position. In making cystograms, he prefers the use of a solution of twenty-five per cent. sodium bromide. In attacking the condition surgically, Rathbun does not consider simple excision of the mucous membrane enough, as a recurrence is liable to take place unless the whole diverticulum, with all its coats is removed. Severe cases should be treated in two sittings. At first, the bladder and also the diverticulum are drained, the latter by stretching its orifice. At the second, radical excision of the diverticulum should be performed. In difficult cases, extra- and intra-vesical manipulation should be combined, the diverticulum being invaginated, and the operation being finished within the viscus.

A CASE OF FOREIGN BODY IN THE NOSE.—This reports a foreign body in the right nasal chamber of a male adult. After removal of the foreign body, which was quite large and had to be removed in sections, it was found that the nucleus was a cherry pit. The symptoms of obstruction had existed for three years. The author suggests the possibility that the patient when eating cherries had sneezed or coughed, forcing the pit up into the nasopharynx and into the posterior part of the nasal chamber.



## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY

Conducted by JOS. V. F. CLAY, M.D.

**EYE SIGN IN MASTOIDITIS.**—Frias Onate (*Jour. A. M. A., Vol. 73, No. 20*) comments on the importance of hyperemia of the papilla as a sign of cerebral complications during mastoiditis. It is particularly instructive when the mastoid process is deceptively free from symptoms. Even with a pronounced clinical picture of mastoiditis the involvement of the brain may escape notice unless the fundus of the eye is examined as a routine measure. Hyperemia of the papilla calls for an immediate operation without wasting time on ice bags, etc. Craniotomy followed by the mastoid operation will save many otherwise doomed patients. In two recent cases this eye sign gave the clue that led to a prompt cure after trephining had confirmed the extra dural abscess. In one of these cases the eye sign was all that differentiated the process from the assumed otogenous meningitis.

**COLON BACILLUS EYE DISEASES.**—Betti (*Abs. Journ. Amer. Med. Asso., Vol. 73, No. 19*) reports two cases of panophthalmitis in men of 56 and 38, following a contusion of the eye. In four and two days the anterior chamber was full of pus, the vitreous all pus, and the eyeball had to be removed. Cultivation of the germs in the eye and inoculation of rabbit eyes demonstrated that a highly virulent colon bacillus was responsible. In a third case, phlegmonous dacryocystitis developed three years after a contusion in the region which had been followed by recurring catarrhal conditions in the conjunctiva after the first stormy inflammation. The dacryocystitis perforated spontaneously and recovery after dacryocystectomy. He cites a few other authors who have reported similar colon bacillus dacryocystitis. The colon bacillus is thus able to induce acute processes in the eye and its annexes with a destructive course.

**THE ACTION OF RADIUM ON CATARACTS.**—Cohen and Lavin (*Journ. Amer. Med. Asso., Vol. 73, No. 16*). The method of application was very similar to the technique of deep radium therapy. The radium covered with brass, photographic paper and gauze was placed on the closed eyelid. Twenty-four cases were treated, twenty were senile of usual type. In the majority both eyes were affected but only one eye which was less mature was treated. Four cases were complicated, one retinitis pigmentosa, one iridocyclitis, two chronic glaucoma.

There was a combined improvement in the lenticular opacification and vision in 12 cases; opacification disappeared in one case without improvement in vision. Opacification diminished in five cases with stationary vision. Opacification stationary but vision improved in three cases. Both vision and opacification remained stationary in three cases.

As a rule the improvement occurred in the first few weeks of treatment. After that the condition remained stationary during the period of observation.

**PERSONAL OBSERVATIONS REGARDING THE TREATMENT OF GLAUCOMA.**—Weeks (*Jour. Amer. Med. Asso., Vol. 73, No. 15*) outlines his views of glaucoma based upon thirty-two years in active practice. He has found that in 90% of cases of idiopathic glaucoma there is a history of chronic constipation and correction of this has much to do with relieving the increased tension. He uses as myotics pilocarpine and eserine. Tension is always tested digitally

and if above normal a tonometer is employed. The use of myotics in idiopathic glaucoma succeeds in decreasing tension and holding vision. Some cases have been held for several years. The effect of myotics in secondary glaucoma is seldom so marked. Experience has taught that early operation is desirable.

In secondary glaucoma accompanying acute or sub-acute iritis the hypertension will usually subside spontaneously in a few days. At times operation is necessary. Paracentesis is usually sufficient.

In acute idiopathic glaucoma this clinician does not find it necessary to operate at the height of an acute attack as tension can be greatly lowered in a few hours by treatment—locally physostigmin 1% every hour if tolerated—calomel purge, morphine hyperdermatically and light diet. If after 12 hours there is no decrease in tension, operate. If tension subsides operation is postponed until the eye has become as nearly normal as possible when a broad iridectomy is performed.

For sub-acute and simple chronic cases he prefers the Lagrange operation except in some cases of buphthalmus in which he prefers the Elliott operation.

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#### CLINICO-PATHOLOGICAL SOCIETY

Reported by J. V. F. CLAY, M.D.

REPORT OF FOUR CASES OF WOOD ALCOHOL POISONING FROM DRINKING BAY RUM.—The report by Dr. N. S. Betts is based upon the findings in four cases of wood alcohol poisoning which occurred during March and April, 1919, at the Marine Barracks, League Island Navy Yard.

It was considered that such case reports might be of value because of the almost universal substitution of methyl alcohol for ethyl alcohol in toilet preparations and on account of the tendency for certain classes of confirmed alcoholics to use any preparation containing alcohol as a beverage in the absence of usual stimulants.

Three of the cases died. They gave histories of digestive disturbance with pains in various parts of the body for 24 to 48 hours before applying for treatment. When serious toxic symptoms developed the end came in from one-half to four hours. The case which survived was seen about eleven hours after drinking three pints of bay rum. All cases had vomiting and epigastric distress, intense nervousness, soft, rapid but regular pulse and, where the man was conscious, complained of dimness of vision and pains in various parts of the body.

The following simple test for the detection of methyl alcohol was devised by Pharmacist R. W. King of the Laboratory of the U. S. Naval Hospital, League Island and depends upon the oxidation of methyl alcohol with the production of formaldehyde and the detection of the latter substance in the material under examination.

To stomach contents or tissue extracts add 10% NaCl solution to precipitate the albumin, then filter. In the case of bay rum it is advisable to decolorize the same by shaking with magnesium carbonate and filtering. The reagents must be tested for formaldehyde to eliminate false results and the material under examination should be tested before oxidation as well as after oxidation. Dilute a few c. c. of bay rum with distilled water, add approximately 0.2 gm. of  $\text{KMnO}_4$  and boil gently for about 5 minutes. During

the boiling a funnel should be kept in the neck of the bottle to prevent loss of formaldehyde if any be present. More potassium permanganate must be added if the fluid in the flask is decolorized while boiling. After the boiling is completed decolorize the mixture with a few crystals of oxalic acid. Put 5 c. c. of this mixture in a test tube and add 2 c. c. of milk, mixing thoroughly. Underlay this with sulphuric acid reagent (100 c. c. of concentrated sulphuric acid plus 1 c. c. of Fehling's copper solution). If formaldehyde be present a violet ring will form at the line of contact.

**PYELITIS IN AN INFANT.**—Dr. C. S. Raue reported the following case: Baby G—, age 14 mos., female, maternal nursing until 10 months. The infant had been in good health until the time of onset of the present illness. The present illness began two weeks ago with fever, offensive stools containing mucus; loss of appetite and fretfulness. The fever ranged from 102.4 to 104.4. Examination of the lungs, abdomen, nose and throat and ears did not reveal a cause for the fever. A fresh specimen of urine was obtained which was slightly cloudy, acid, and showed a trace of albumin, a few hyaline casts and an abundance of pus cells. A gram negative bacillus was also present. This was suspected of being the colon bacillus and a culture was made from a catheterized specimen of urine. The colon bacillus was isolated in pure culture. An autogenous vaccine was prepared and after the first injection the temperature became remitting and reached normal in the morning. The leucocytes gradually fell from 46,000 to 20,000 and finally reached normal. After the third dose of vaccine the temperature remained normal. Beside the vaccine the child also received cantharis 6x. The urine gradually cleared up and at the end of a week after treatment was begun it was clear, only showing a few pus cells under the microscope.

## UROLOGY

Conducted by LEON T. ASHCRAFT, M.D.

**THE TREATMENT OF CHRONIC URETHRITIS, WITH A DESCRIPTION OF A NEW INSTRUMENT FOR CAUTERIZING THE LACUNAE.**—Powell (*Brit. Med. Jour.*, 1919, XX, 161) says that in inflammation of the penile portion of the urethra, the passage of sounds should be undertaken as soon as the subacute stage is reached. If there is still a discharge after this, the author thinks it is because the infection persists in the lacunae. He has devised a sheath to fit into the wall of an air urethroscope, through which a probe can be passed. By means of this instrument he is able to cauterize the lacunae individually, either with silver nitrate or by means of fulguration. If the prostate has not become involved, this will cause the discharge to diminish and finally stop. The author believes that the ease with which old reinfecting cases are often cured is due to the altered condition of the lacunae, and the inability of the organisms to find a lodgment in them. Their appearance in these cases is that of shallow pouches, and a similar appearance is produced by cauterization.

**TUMORS OF THE URINARY BLADDER.**—Kolischer and Eisenstadt (*Surg. Clin.*, Chicago, 1919, III, 531) reports four cases, one benign, and three malignant. They advocate fulguration for the treatment of benign growths. The treatment of malignant neoplasms is most unsatisfactory. Radiotherapy is becoming more generally employed, there being no primary mortality and



a considerable percentage of clinical cures. Suprapubic cystotomy relieves the intolerable suffering of advanced malignant disease, secures drainage, permits control of the hemorrhage and allows of the direct application of radium to the growth through the wound.

THE INJECTION OF AIR FOR THE ROENTGEN DIAGNOSIS OF TUMOR OF THE BLADDER.—Phahler (*Amer. Jour. of Roentgenology*, 1919, VI, 371) believes this method to be one worthy of more extended application. It adds to the cystoscopic findings; or, in cases in which cystoscopy is, for any reason, impossible, it may take the place of the latter. The technique is simple and harmless. By this method, one may demonstrate the presence of new growths, enlargement of the prostate, diverticula and calculi.

INDICATIONS FOR OPERATION IN URETERAL CALCULI.—Eisendrath (*Ann. Surg.*, 1919, LXX, 192) does not appear to place much reliance upon radiography for the diagnosis of ureteral calculi. The shadows may deceive even the trained roentgenologist. Stones in the ureter may give rise to no symptoms until the kidney becomes infected. The various sequelæ produced in the ureter are as follows: (1) Uniform dilatation above the stone; (2) stricture at the point of impaction; (3) periureteral abscess. In the kidney the calculus causes: (1) pyelonephritis; (2) infected or non-infected hydronephrosis; (3) perinephritic abscess; (4) calculus anuria; and (5) generalized sepsis. Operation should not be resorted to until several attempts have been made to deliver the stone by manipulation. If there is much fever, however, the operation should be performed at once. Acutely infected cases should be treated by open operation, unless the abscess can be drained by a catheter through the ureter. In cases of anuria, unless the stone can be delivered with the cystoscope in two or three days, operation must be performed.

APPARENT CURE OF CARCINOMA OF THE BLADDER BY RADIUM.—Jeek (*Internat. Jour. Surg.*, 1919, XXXII, 240) reports a case in which, on cystoscopic examination, there was removed by the operating cystoscope a small fragment of a red papillary growth, sloughy in parts, about the size of a raspberry, situated near the left ureteral orifice. Microscopic examination showed it to be a squamous celled epithelioma. A month after the first application of radium emanations through the cystoscope, the dose being 476 millicurie hours, no change in the growth's appearance was noted. Another treatment was given, and a month later cystoscopic examination showed only a slight raised area, about the size of a nickel. Two months after this, another cystoscopic examination showed a recurrence on the site of the original growth, there being an elongated tumor about twice the size of the index finger! A third application of radium was made, the dose being 700 millicurie hours. The symptoms were relieved; and two months later there was merely to be seen a reddish area about the size of a dime. Two months later still, the bladder was found to be entirely free from any sign of tumor. The patient remained well and has gained in weight. The last cystoscopic examination was made in May, 1919, and the bladder mucosa then still looked perfectly normal.

# THE HAHNEMANNIAN MONTHLY.

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APRIL, 1920

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## LABORATORY OBSERVATIONS OF THE INFLUENZA PANDEMIC.

BY

R. S. LEOPOLD, M.D., GERMANTOWN, PHILA., PA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 18, 1919.)

JUST one year ago, at this time, we were entering that memorable period the scourge of Influenza. That period when all medical men were taxed to the limits of physical and mental endurance, when no time was to be spared for scientific analysis of etiological and clinical facts, when all was rush and chaos.

This medical man has no doubt at many times wished to review his observations, his impressions and his conclusions of that pandemic period, if only to coldly compare them in such perspective with other independent observations.

Especially should I, therefore, assume that laboratory men would be interested in a review of much of the data of an individual co-worker.

It is therefore the purpose of this paper to present such laboratory observations on the Influenza Pandemic as were collected while in the service of the U. S. Forces; as well as some personal opinions, pertinent thereto, which were conceived at the same time.

These observations\* are based on an intensive study by a detailed laboratory force, directed by the writer, on a series of 2124 cases of Pandemic Influenza.

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\* Extracted from a report, by the writer, published in the United States Naval Medical Bulletin, October 1919.

The condensed data to be presented, and from which pertinent opinion was formulated embraces the following:

Blood. Complete pictures .....	605	
Sputum. Morphologic and cultural.....	578	
Cultures. Exudates, etc. ....	90	
Lung punctures .....	41	
Pneumococcus typing .....	91	
Blood cultures .....	18	
Spinal fluid .....	48	
Necropsies .....	15	
Vaccines, B. influ. pandemic strain .....	60	Therapeutic
Vaccines. B. influ. pandemic strain.....	280	Prophylactic
Urinalyses .....	2,130	

**BLOOD.**—Following an intensive study of selected cases, we were able to establish a blood picture in uncomplicated influenza of an absolute and relative Leucopenia with, in many cases, a relative Lymphocytosis.

The white count varied between 3500 and 8000, the polynuclears between 50 per cent. and 80 per cent., lymphocytes between 20 per cent. and 42 per cent.

In post influenzal pneumonia, the blood picture was usually quite different. In these cases, the white count varied between 14,000 and 20,000, polynuclears from 75 per cent. to 98 per cent. and lymphocytes from 1 per cent. to 20 per cent. There seemed also to be a relative lowering or absence of large mononuclears. Those cases progressing favorably maintained a high or rising white count, although a falling count, while indicating an unfavorable clinical state, seemed not necessarily to define a fatal issue. Many cases while maintaining a slowly decreasing white count for many days, eventually recovered. Occasionally, a slight eosinophilia in those cases with splanchnic insufficiency was noted.

An interesting and valuable observation in the daily blood pictures was the gradual or hurried change from the blood picture of uncomplicated influenza to that of the blood findings of pneumonia, and we were able, here, by noting the rising white count and falling Lymphocytes to anticipate the clinical findings of broncho-pneumonia by several days.

In a series of over 600 blood counts, we have selected 100 cases of verified uncomplicated influenza and 100 cases of post influenzal pneumonia from which to construct a composite white blood picture.



TABLE NO. 1.

Composite picture of complete white blood counts of one hundred cases of uncomplicated influenza and of one hundred cases of pneumonia, at the crest of epidemic:

	W. B. C.	Polys.	S. Lymph.	L. Lymph.	Mono.	Trans.	Eos.	Bas.
Influ.	6,950	67.5	21.2	3.8	4.4	2.1	0.7	0.3
Pneum.	17,680	82.8	8.3	2.1	2.6	3.8	0.3	0.1

In four differentials a neutrophilic degeneration of polynuclears was noted, marked granulation of the protoplasm of the lymphocytes was noted in one case.

TABLE NO. 2.

Table No. 2 represents the average blood picture from several daily examinations of 25 cases each of typical influenza and of post influenzal pneumonia, studied from a clinical and laboratory standpoint during a parallel period of the epidemic.

AVERAGE BLOOD PICTURE OF TWENTY-FIVE CASES OF TYPICAL INFLUENZA.

September 26th to October 26th, 1918.

W.B.C.	Poly-nuclear	Small Lymph	Large Lymph	Mono-nuclear	Transitional	Eosinophile	Basophile
5,600	58	36	2	3	1		
4,800	65	30	4	1			
6,300	62	20	7	3	1	1	
8,400	80	15	2	2	1		
5,100	77	12	0	6	5		
8,000	65	15	5	10	5		
8,000	77	10	0	11	2		
6,800	55	28	4	10	2		
7,900	58	27	0	12	0	3	
3,500	80	8	6	4	2		
6,300	80	20					
4,900	71	26	1	0	2		
7,000	79	12	6	3			
8,000	76	15	4	2	3		
6,700	61	21	10	7	1		
5,800	79	10	5	2	3		
3,600	67	23	0	7	3		
6,500	63	29	0	5	3		
5,800	77	18	1	3	0	1	
7,200	71	20	6	0	2	0	1
6,900	71	19	4	0	3	2	1
7,100	73	22	3	1	1	1	
5,900	69	22	4	0	3	2	
6,900	71	19	4	0	3	2	1
5,400	65	25	2	6	2		

AVERAGE BLOOD PICTURE OF TWENTY-FIVE CASES OF  
PNEUMONIA.

September 26th to October 26th, 1918.

W.B.C.	Poly-nuclear	Small Lymph	Large Lymph	Mono-nuclear	Transitional	Eosinophile	Basophile
22,600	95	2	1		2		
13,600	88	6	1	2	3		
12,100	75	3	3	9	6	2	2
16,000	77	12	4	1	3	2	
16,500	85	10	0	1	4		
12,000	89	3	0	4	4		
15,600	90	1	1	2	6		
49,900	86	0	1	1	12		
69,600	92	2	0	1	5		
24,300	87	2	2	4	5		
22,800	88	12					
14,000	86	7	0	2	5		
20,200	84	2	4	4	5		
19,000	91	2	1	1	5		
43,000	98	1	0	1			
25,600	82	10	0	2	6		
25,000	82	2	2	9	5		
28,600	92	3	0	0	5		
20,900	86	5	0	4	5		
18,900	81	13	0	4	1	1	
19,600	79	12	5	1	3		
15,600	78	10	5	4	2	1	
23,800	82	16	0	0	2		
17,500	77	20	1	1	1		
13,600	82	17	0	0	1		

SPUTUM.—Early in the epidemic a cultural study of the sputa was attempted, but because of unfamiliarity with the peculiar cultural requirements of the B. Influenza, as later referred to in detail, as well as the pressure incident to the epidemic, this detail we find untrustworthy and is omitted.

While a report of a morphological study of sputa unsupported by cultural verification is inconclusive, we have selected 200 cases from over 600 examined, for statistical classification.

These were freshly collected, using every possible precaution against mouth and post-nasal contamination and assuring ourselves of fresh bronchial secretions. It was quite surprising, in those cases with a productive cough, to note the very low incidence of extraneous contamination, and especially, in those fulminating epidemic types, to find the high percentage of sputa showing a pure B. Influenza.

TABLE NO. 3.

CLASSIFICATION OF TWO HUNDRED SPECIMENS OF SPUTA  
(INFLUENZA CASES.)

September 28, 1918 to October 28, 1918.

1. B. Influenza (pure) .....	18%
2. B. Influenza and Streptococci .....	14%
3. B. Influenza and Pneumococci .....	12%
4. B. Influenza, Strep. and Pneumo. ....	12%
5. Pneumococci .....	10%
6. Streptococci .....	15%
7. Pneumococci and Streptococci .....	18%
8. Total B. Influenza present .....	62%

In sputa of patients convalescent two to three weeks, B. Influenza, were still present in appreciable numbers in 36 per cent. of cases examined; thus demonstrating the possibility of a high percentage of carriers; with the concomitant flare backs, amongst the non-immunes, in subsequent months or years.

An especial point of interest in the sputa of cases gravely ill with pneumonia, especially those with bloody sputa, was the presence of a definite spirillum. This spirillum seemed constant in its morphology as a relatively short one, with curved ends, even and regular convolutions, about six to eight in number and staining faintly with strong fuchsin was imbedded in the muco purulent exudate apparently from the lower respiratory tract.

We were perfectly cognizant of the usual mouth types and on the alert to eliminate these, but several points impressed us as to their possible importance:

1. In nearly every case it was associated with bloody sputum.
2. In nearly every case, where spirilla were found, fatal termination was early and rapid.
3. The associated organism was that of a predominating B. Influenza.

From lung punctures we have not been able to absolutely identify this organism either in stained or dark field examination.

Several theories occur to us:

1. That it might be related to the Pulmonary hemorrhagic spirochaete of Castellani, recently observed in France by Barbary, Wolf and others.
2. That in the extreme toxic asthenias due to the B. Influenza, certain inoffensive buccal spirochaete might



become pathogenic in a manner quite similar to the pneumococcus and streptococcus; and invading the bronchi set up a specific infection.

3. Spirochaete are associated with war nephritis, trench fever and jaundice and if the first two theories are tenable, then with immense grouping of military men, with the unavoidable exposures, imperfect sanitation, generalized "barrack catarrh," and rapid group transportation, it is not inconceivable that an unrecognized strain might thus suddenly light up amongst a world of non-immunes, as a specific lung invader.

This spirillum suggested the advisability of arsenic therapy in a group of those pneumonias, with the spirochaete, and later those without spirochaete. In all cases this spirillum disappeared after Salvarsan therapy, and at no time were we able to demonstrate it again during their convalescence.

TABLE No. 4.

Sputa of 91 cases were typed with the following results:

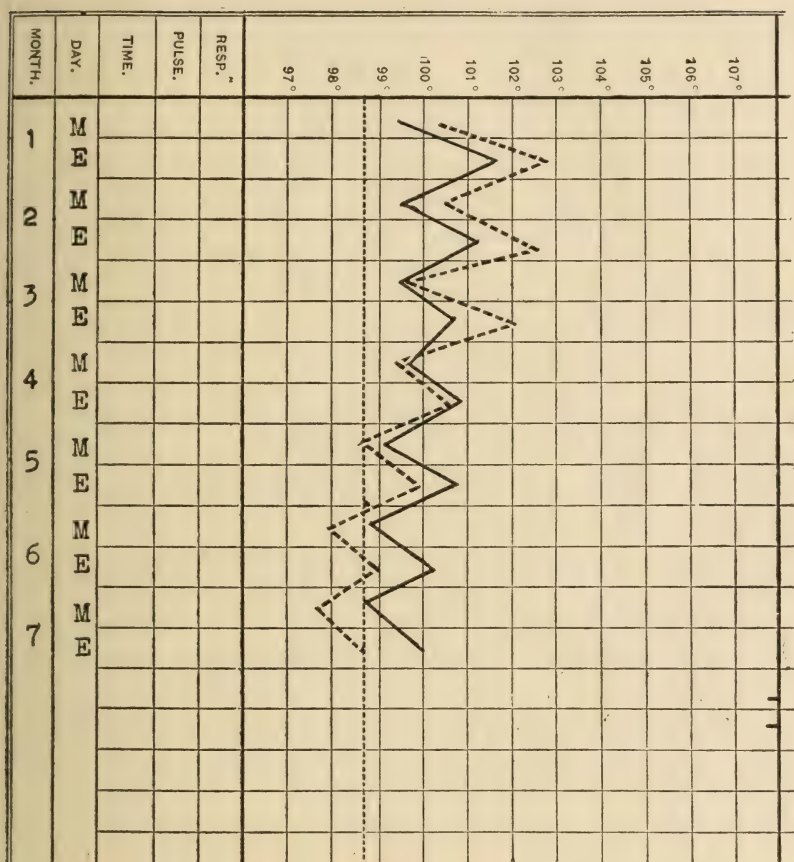
Type I .....	1.1%
Type II .....	12.3%
Type II(a) .....	14.6%
Type III .....	5.6%
Type IV .....	25.8%
Negative .....	40.6%

In a group of 20 negatives, six returned B. Influenza in pure culture at white mouse necropsy.

VACCINES.—(a) *Therapeutic*. About 60 cases of typical influenza have been vaccinated, the majority receiving no other treatment with apparently little immediate effect on the course of the disease, except a fall of temperature probably 24 hours earlier than control cases (see composite chart.)

Of the vaccinated influenzas, three developed bronchopneumonia, one three days after last injection and two five days after last injection. Of these cases two had very mild infections and recovered rapidly. One had very severe type, with sinus complications, but recovered.

A composite graph has been plotted of 16 vaccinated cases and 16 unvaccinated, as closely parallel as possible as to clinical conditions, period of epidemic, etc.



Remarks.—Records begin on day after admission. Sixteen vaccinated cases received one mil of suspended B. Influenza for three successive days, and no other treatment. Sixteen unvaccinated cases received routine treatment. All cases admitted October 10-22, inclusive.

Vaccinated cases—Dotted line.

Unvaccinated cases—Black line.

VACCINES.—(b) *Prophylactic*. About 280 of personnel, in contact with the sick, have been vaccinated with varying doses and methods. All cases exhibited mild local and general reactions. A number developed within three to five hours varying degrees of sharp general reactions, chill, headache, injected eyes, nausea, anorexia, backache, joint and bone pains, fever, etc., lasting 8 to 20 hours, but all returned to normal in 24 hours.

In substantiation of the local and general reactions blood pictures made in several cases showed a fairly constant but mild, absolute and relative leucopenia, this appearing about three hours after injection but returning to normal in 24 hours.

In vaccinating therapeutically, our aim was to develop a technic allowing as early and rapid vaccinations as possible. With the suspension used, we were able to introduce three doses in the following manner: the first 0.1 c. c. intravenously, twelve hours later a subcutaneous dose of 1.0 c. c. and a third like dose 24 hours later.

This rapid method was attended in proper doses by very little or no uncomfortable reactions.

In no case did any vaccinated influenza develop pneumonia later than the third day. Prophylactically where speed was not essential our routine vaccination consisted of a subcutaneous injection of 1.0 c. c. on each day for three consecutive days.

Since the period of voluntary vaccination was instituted in a group of 50 unvaccinated contacts, 16 per cent. have developed influenza, while of the larger group of 280, although remaining constantly in contact, none has developed influenza.

The vaccine used was prepared by Dr. Paul A. Lewis, and was a suspension of pure B. Influenza, and the technic of preparation and injection were all carried on under his direction.

TABLE No. 6.

COMPARATIVE DATA ON VACCINATED AND UNVACCINATED CASES.

October 6th to 26th, inclusive.

Number unvaccinated influenza cases .....	221
Number pneumonia cases developing .....	78
Proportion influenza developing pneumonia .....	35.3%
Total deaths from pneumonia cases .....	56
Number vaccinated influenza cases .....	60
Number developing pneumonia .....	3
Proportion influenza developing pneumonia .....	5%
Number of deaths resulting from pneumonia.....	0

TABLE No. 7.

URINALYSIS REPORT.

Number of specimens examined .....	2130
Albumin present .....	614
" " .....	28.8%
Pus cells present .....	204 9.6%
Casts present .....	182 8.6%



In a series of 25 Phthalein functional tests a marked irregularity of renal efficiency was noted.

BACTERIOLOGY.—The striking feature of this epidemic has been the extreme difference of bacteriological opinions. Some claim a high percentage of B. influenza, while others support ridiculously low or even negative findings.

The very character of the reports which have been so numerous and varied mean either that the virus of this epidemic remains as yet absolutely unrecognized, or that the cultural vagaries and pathogenic properties of the B. influenza have been so incompletely developed as to mask the entire etiological picture. In spite of many discouraging features of the literature, as well as those of our own observations, unless some entirely new agent is finally found, we feel that perfection of cultural requirements and especially intensive investigation of the pathogenicity and immune factors will finally determine the B. influenza of some definite strain, as the true causative factor. We also feel that our findings would have been of greater value had our technic been identical from the origin of the epidemic.

Our final technic, for many suggestions for which we are indebted to Dr. Paul A. Lewis, was to plate on blood agar (0.4 per cent. acid, glucose agar with 1 per cent. defibrinated human cells) incubate for 24 hours at 37°C. and subsequently at *room temperature*.

Repeated inspection with lens, in reflected and transmitted light twice daily, for several days before discarding, has been our rule, as we have repeatedly discovered colonies 4 to 5 days later. Suspicious colonies were then cut out, planted for 24 hours in blood bouillon and re-plated in blood agar when usually an abundant growth is returned.

On the liquid medium many vague involution forms are seen; from long filamentous to broad convoluted bodies, very much resembling contamination or anything but B. influenza, but on replating on agar, these forms disappear and the characteristic minute, glistening transparent colonies of a gram negative cocco-bacillus appear.

We feel that many of our failures in early attempts were due to a failure to recognize the following sources of error:

1. Reincubation after the first 24 hours instead of room temperature.

2. Unsatisfactory culture media.
3. Subculturing in solid media without interposing a liquid medium.
4. Failure to recognize young colonies.

For this reason we have discarded many of our earliest efforts and confined our report to a period during which our technic was sufficiently exacting to satisfy ourselves.

Several attempts at complement fixation were unsatisfactory, in our hands, owing to an extremely narrow margin between the antigenic and anti-complementary units of the suspensions used.

NECROPSIES.—Of fifteen necropsies performed, only nine were studied completely, pathologically and bacteriologically to warrant a report in full. These cases were all classical post-influenzal broncho-pneumonias.

A composite necropsy picture of these would present a report somewhat after the following:

A robust, muscularly well developed young man, with extreme cyanosis of the entire body, amounting in most cases to a deep purplish black, and a characteristic foul odor. This gross appearance and odor was a constant characteristic of our morgue the entire period, during which only epidemic cases were admitted to our hospital.

Anatomically an extreme engorgement of the venous circulation, such as is seldom seen, likewise a constant picture. All subcutaneous veins are distended and bleed freely of a thin black fluid, watery in consistency and staining everything a dark mahogany color. The cavæ and right heart are enormously engorged and over-distended and are filled with a blackish jelly-like clot, while the abdominal veins are so extremely distended as to graphically demonstrate the extent of the venous sump into which the circulation is constantly overflowing.

The heart muscles are all well developed, but have a glazed or scalded appearance. The pectoral and recti muscles also present the same appearance.

Few of the earlier cases showed pleural involvement beyond an occasional serous effusion. After the crest of the epidemic a few cases of sero-purulent pleuritis were seen.

The lungs exhibited a constantly varying picture of broncho-pneumonia, from a peppering of discrete lobular areas well scattered throughout all lobes, to large and oftentimes

massive confluent broncho-pneumonia areas involving approximately 75 per cent. of the lungs.

In the discrete type, distinct areas of lobular pneumonia in various stages of development are seen, well defined, elevated and firm; of a reddish brown, varying to a bluish gray color, and surrounded by normal or collapsed lobules. The shades of color of the bulging pneumonic lobules surrounded by the red congested, uninvolved and pale collapsed areas giving the whole a mosaic appearance.

In this type often from 25 per cent. to 50 per cent. of the lungs were involved, usually as single or at most confluent two or three lobules.

In the massive involvements fully 75 per cent. of the lungs are involved, in the order of frequency as R. lower, L. lower, R. middle.

The involved areas are of a bluish gray color, varied here and there by paler patches of later involvement, or by dark streaks of subpleural hemorrhagic extravasations.

In all types areas of extreme emphysema of a most marked degree are present in portions of the uninvolved lobes.

On cross section, the larger areas exude a thin, black stained watery fluid in great quantities, and the cut surface seems smooth of a dark slate color and with no mucous or fibrinous character.

The discrete areas are a mahogany or bluish brown color, have a distinct granular appearance, and seem almost to bulge or pop out of their restraining alveolar capsule.

The bronchi and larger roots contained a thin brownish mucoid like membrane, of a tenacious character, and minute petechial hemorrhages are peppered in and apparently beneath the mucosa.

Quite a nest of very hard and firm peri-bronchial glands are often found about the lung roots.

The spleen, liver and especially the kidneys exhibit varying degrees of congestion. The spleen is somewhat enlarged and of a very deep purplish hue, while the cortex of the kidneys has a deep brown color and a glazed bulging surface. The adrenals are distinctly enlarged, very friable and of a deep bronze shade.

MICROSCOPICAL.—Sections taken through smaller lobular areas and larger confluent masses reveal a fairly uniform



picture of broncho-pneumonia, the findings varying only in proportion to the degree of involvement.

Everywhere the inter-lobular capillaries are intensely congested, in spots becoming broad hemorrhagic extravasations. The alveoli are packed with red cells, leucocytes, fixed cells and debris, but no fibrin. Where the involvement is less extensive fewer cells, probably coagulated serum and larger mononuclear cells are found. Peri-bronchial and peri-vascular round cell infiltration is especially pronounced about the broncho-pneumonia areas.

The general appearance of the heart muscle is that of a faint staining myocardium, marked congestion and some groups of round cell infiltration between bundles of the muscle fibres. The individual cell often seems swollen, of a faint granular appearance, the nucleus is clouded and the capsule indistinct, while occasionally minute hemorrhages within the bundles, with small collections of leucocytes, are seen. An interesting feature of two cases is the distinct proliferative activity of the intima of the larger vessels.

The liver and spleen while intensely congested show no active inflammatory changes. Occasionally a sharp biliary pigmentation is present.

The kidneys uniformly exhibit more advanced inflammatory changes. The congestion here is extreme, the capillaries seem almost bursting, while extravasation from the same in and around the loops of the glomerular and intertubular vessels are quite common. An advanced cloudy swelling, especially of the convoluted tubules is noted in all cases. In a few cases glomerulo-tubular inflammatory changes are undoubtedly taking place.

The adrenals exhibit the same intense congestion but without progressive inflammatory changes.

Case No. 7 is an interesting epidemiological study. This being one of about 25 men received from a ship which had been at sea during the height of the epidemic and on which within 48 hours of arrival at this port, a large proportion of the liberty party became stricken. Post nasal cultures of a group of these cases gave a high per cent. B. influenza, and this case (No. 7) a very strikingly rich culture. One week later he developed the typical post influenzal pneumonia. Two

CHART OF NINE NECROPSIES. POSTMORTEM CULTURES.

Sick days	Sputum	Average W.B.C.	Blood Culture	Urin- alysis	Lung puncture antemortem	Pneumonia areas	Bronchi etc.	Necropsy finding	Microscopic
No. 1	7 B. Infl. Strep.	11,200	not taken	Alb. & cast (x)	not taken	B. Influenza (pure)	Strepto. pneumo.	Discrete Broncho-pneumonia	Broncho.-pneumo cloudy swelling Kidney
No. 2	7 B. Influenza (pure)	8,000	ster.	Neg.	not taken	B. Influenza (pure)	B. Infl. Strep.	Confluent Bron.-pneumonia	Broncho-pneumo, Toxic myocarditis Myocard. arteritis
No. 3	1 B. Infl. strep. pneumo.		not taken	Alb. & cast (x)	not taken	B. Infl. strep. pneumo.	B. Infl. Strept. (pneu. type neg)	Massive Bron.-pneumonia	Same as No. 1
No. 4	7 B. Infl. Strep. pneumo.	6,300	Strep. hemoly	Alb. & cast (xx)	B. Infl.	B. Influenza (pure)	Strep. hem. pneu. (type neg.)	Discrete Bron.-pneumonia	Same as No. 1
No. 5	5 B. Influenza (pure)	7,000	ster.	Neg.	M. Catarr.	M. Catarrhal	Gr. pos. Bac. (?)	Discrete Bron.-pneumonia	Same as No. 1
No. 6	3 Strept. pneumo. staph.	17,200	"		Strepto.	B. Influenza Strepto.	Strepto. spleen B. Infl. (?)	R. Sero. fib. plur.	Same as No. 1
No. 7	12 B. Influenza (pure)	5,200	"	Alb. & cast (x)	Strep. pneu.	B. Influenza Strepto.	Strepto. pneumo.	R. Sero. fib. plur.	Same as No. 2
No. 8	8 B. Influenza (pure)	4,000	Pneu. (III)	Alb. & cast (x)	B. Infl. Pneu. (III)	B. Influenza Pneumo. (III)	B. Infl. pneu. (III)	Discr. Bron. pneumonia	Same as No. 2
No. 9	3 No report	4,200	Ster.	Alb. & cast (x)	Contamina-tion	B. Mucosus	B. Mucosus, Strep.	Confluent Bron.-pneumonia Mucopurul. pleur	Same as No. 1
Aver.	6 B. Infl. predom. 37% mixed 37% Strep. pneu. and Staph. 25%	7,888	28%	75%	B. Infl. 40%	B. Infl. pure 33% " mixed 44%			

others exhibiting a sparser growth of *B. influenza* also developed pneumonia, but recovered.

TABLE No. 9.

OCCURRENCE OF ORGANISMS IN CULTURE IN 31 OTHER LUNG PUNCTURES.

<i>B. Influenza</i> (predominating) .....	8 (35%)
"    with <i>Strepto-pneumococcus</i> .....	3
"    " <i>M. Catarrhalis</i> .....	2
"    " <i>Staphylococcus aur</i> .....	1
"    " <i>B. Mucosus</i> .....	1
Total <i>B. Influenza</i> .....	(65%)
<i>Pneumococcus</i> (III, IIa) .....	2
<i>B. Mucosus</i> .....	2
"    with <i>Pneumococcus</i> (IV) .....	1
<i>M. Catarrhalis</i> .....	1
<i>Staphylococcus aureus</i> .....	1

TABLE No. 10.

OCCURRENCE OF ORGANISMS IN CULTURE FROM PLEURAL FLUID.

<i>Streptococcus</i> .....	5
<i>Streptococcus hemolyticus</i> .....	1
<i>Pneumococcus</i> (I) .....	1
"    (III) .....	1
"    (IV) .....	1

The case of Type I was given intra-thoracic administration of 50 cc of its serum, and a like dose intravenously with rapid and marked improvement, for type I pleurisy.

In the lung puncture (Table No. 9) made during life, care was taken to carefully outline areas of consolidation and using a powerful 20 mil. syringe, containing about 3 to 5 mls. citrated saline, to plunge through sterilized skin surface directly into these. Cultures were made in blood agar and blood bouillon. Obviously it was quite impossible to obtain as uniform and satisfactory material as when made at necropsy; yet the result of the bacteriological findings are quite comparable with those of Table No. 8.

This operation was attended with very little discomfort and no unfavorable complications.

COMMENTARY.—Surveying the epidemic, our general impressions, as gathered from laboratory and clinical study, may be summarized as confusing and broadly speaking, non-productive and our opinions as largely theoretical.

Unfortunately, in our experience, as was the case in



many others we presume, we do not feel that our technic was sufficiently acute in the earlier days of the epidemic to detect the constancy of the influenza bacillus.

Taken as a whole, however, our percentage of positive findings was sufficiently high to establish the term influenza to the epidemic. This with the clinical picture satisfies the uncomplicated cases.

As to the high incidence and mortality of the post-influenzal pneumonias, we have only theories in explanation, namely:

1st. That the pneumonia was a true primary B. influenzal invasion of the lung parenchyma.

2nd. That intercurrent with a very active influenza pandemic was carried a pandemic of pneumonia of unestablished origin.

As to the first supposition, we have found a high percentage of pure B. influenza in antemortem lung punctures, carefully made from localized areas of consolidation.

More strikingly have been the results of necropsy where, on several occasions, we isolated B. influenza in pure culture from the discrete lobules of lobular pneumonia. From the peri-pneumonic areas and bronchi never pure B. influenza but usually secondary invaders.

This we felt at the first few attempts convincing evidence of the extension downward of the organism; and satisfied our impression that the entire clinical complex was simply an inflammatory invasion of the entire respiratory tract, *a priori* B. influenza in origin. Subsequently, however, we were not able constantly to demonstrate the B. influenza in the lobular patches of consolidation, and, unfortunately, by this time the crest of the pandemic had passed.

We feel thoroughly honest in ascribing to the B. influenza the causative factor in the influenza pandemic. To say that such were the case in the post-influenzal pneumonias is decidedly insufficient, unless we can demonstrate a particular strain or strains of B. influenza possessing a virulence and specificity as yet unknown.

As to the second supposition, we cannot feel from our experience, nor can we gleam from the mass of literature presented, honest in ascribing to the B. influenza alone the full burden of the high incidence of pneumonia.

Several facts again present themselves:

(a) No case of pandemic pneumonia that came under our observation failed to present the clinical signs of influenza well before any pneumonic symptoms were recognized. Thus apparently demonstrating a distinct relationship of the causative factor (*bacillus influenza*) in the uncomplicated influenza and the post influenzal pneumonia. From a clinical standpoint, this would seem of sufficient evidence to establish the presumption of a simple extension of the B. influenza into the lung parenchyma. Bacteriologically, however, the facts do not support this.

(b) The post-influenzal pneumonias were all so clinically similar that the causative agent, if known, should be relatively constant. This was again not the case. B. influenza, which was found in the highest percentage, was decidedly not a constant factor; nor even in these high percentages are there any facts so far presented to establish its specificity.

We are justified, therefore, with no further facts at hand, to present presumptuous theories in an effort to explain the nature of the recent pandemic. These would be:

1st. That a true pandemic of influenza, caused by the B. influenza, prevailed; differing only from the frequent sporadic outbreaks in its virulence and pandemic qualities.

2nd. That a certain percentage of these typical uncomplicated influenzas may have progressed to a true influenzal pneumonia.

3rd. That parallel with the influenzal epidemic there was present a pandemic of pneumonia, due to an unknown organism or agent and one which may have existed symbolically or by preference with the B. influenza. This agent causing the great majority of the fatal pneumonias.

4th. That, as suggested above, this agent may be some exalted strain of a non-pathogenic mouth organism, the subject of inversion or transmutation as the result of the unusual interchange of respiratory organisms, incident to the mobilization of military masses.

5th. That supported only by our own thoroughly unestablished presumption we believe this organism to be a spirillum because:

(a) A spirillum was found during the height of the pandemic strikingly unlike usual mouth organisms.

(b) It is as thoroughly tenable to attribute pathogenic possibilities to mouth spirilla as to mouth streptococci, etc.

(c) Pathogenic spirilla have been demonstrated in the lungs, kidneys and liver incident to war infections.

(d) Spirilla have been demonstrated in animal, notably horse, pneumonia; while veterinarians assert a pandemic in animals paralleled the influenza epidemic.

(e) The morbidity age of 18 to 35 paralleled that of the military age.

We wish to reiterate that we present the above theories, unsupported by facts, not with any claim for acceptance or originality, but only that, in the light of totally negative or confusing reports, some seemingly unopened direction may be presented along which to further extend our efforts to clarify the etiology of the recent conflagration.

#### DISCUSSION.

DR. JOHN G. WURTZ, Pittsburgh: I had an opportunity to study influenza, but not so thoroughly and systematically as Dr. Leopold has studied it. It pleased me to hear that the type I pneumococcus was so scarce. I want to ask whether, after the lumbar punctures, any cases developed a meningitis. I cannot recall just what his results were with the blood cultures of these cases; but one of the medical gentlemen made the statement that when there is bacteremia, lumbar puncture is contraindicated because, while the spinal fluid may at first be negative, after the pressure is relieved, the bacteria in the blood get into the spinal canal and cause secondary meningitis. I should like to have Dr. Leopold tell me whether there were any symptoms or cases of meningitis developing after lumbar puncture. This is not a reflection on the technique of doing the lumbar puncture; because no matter how carefully it is done, there may be secondary infection from the blood. It is usually done under aseptic precautions, and there should not be infection from the needle.

DR. R. S. LEOPOLD, Philadelphia: In reply to Dr. Wurtz's question as to the value of blood cultures, I may say that they were, of course, uniformly negative, for the bacillus influenzae. Frick isolated a bacillus from one case, which from the cultural and morphological description corresponds closely with the bacillus influenzae. This is the only case on record which I have seen, in which it was isolated from the blood stream. Of the positive findings, in all our blood cultures all were of the pneumococcus-streptococcus group.



I am glad that Dr. Wurtz brought up the question of typing. General reports give about 30 per cent. of Type I as the usual finding. This has always been a source of surprise to me, as I have found cases of Type I only too infrequently. We are all pleased to find such cases and to rush Type I anti-serum therapeutics. I am convinced, however, that the predominating type is purely a question of locality. Reports of men from the Southern camps showed a high percentage of Type IV, and some on the Western coast had an unusual percentage of Type I. I tried to find out the climatology in the cases that came to us, and when we had a draft from these localities I tried to see whether the type percentages corresponded. I must say that they did, and that from that I believe it likely that for each local epidemic there is a predominating type of pneumococcus.

To explain this, I have often questioned whether each strain might not go through a period of attenuation after each local epidemic, or, for that matter, after each pandemic, and so lie dormant as it completes its cycle of hibernation, then taking on a period of exaltation it bursts out, as it completes its cycle, in renewed numbers and overpowering virulence and another epidemic follows. We see this often in plant and animal life, specifically and graphically in the seven year locust and the army worm. All these we see occasionally, but at periods they appear in unheard of numbers and activity.

After lumbar puncture, in no case did meningitis develop. We made spinal punctures only in cases showing marked meningeal irritation. Almost all cases showed a toxic meningismus. We carried out lumbar puncture as routine measure, but got little or no help from it, and certainly no ill effects.

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TREATMENT OF EPIDEMIC ENCEPHALITIS.—Barker and his colleagues offer the following conclusions based upon eight cases: "The patients under our observation have evidently been of the milder type, as none of them died. Convalescence has been tedious in several of them, and in how far there will be residual phenomena in some, it is as yet too early to be sure.

"At the onset of the disease, rest in bed, protection from external stimuli of all kinds, laxatives, bland diet and relief of headache and of pains would seem to be desirable.

"In our experience, lumbar puncture, done for diagnostic reasons, relieved the symptoms so markedly in several instances that it was repeated at intervals as a therapeutic measure.

"During convalescence, prolonged rest, careful nursing, a nutritious diet and mild hydrotherapy, electrotherapy and massage have been the only measures made use of. Complete recovery without residuals seems to be common."—*American Journal of the Medical Sciences*, March, 1920.

**TUBERCULOSIS OF THE STOMACH AND THE OESOPHAGUS, WITH  
REPORT OF A CASE.**

BY

S. W. SAPPINGTON, M.D., PHILADELPHIA.

**I. TUBERCULOSIS OF THE STOMACH.**

**HISTORICAL.** The first mention of tuberculosis of the stomach is probably to be credited to Barkhausen in 1824. His case, however, is considered very doubtful. Others have assigned the priority to Andral and Cruveilhier in their work on pathologic anatomy in 1842. It is interesting to note that the first description of syphilis of the stomach was from Andral in 1834. Bignon, in 1853, published a doubtful case of tuberculous ulcer of the stomach in a child. Occasional reports followed, but between 1875 and 1882 a number of excellent histologic descriptions appeared, authentic as possible before the discovery of the tubercle bacillus. Of these may be mentioned the cases of Litten, Breus, Talamon and Eppinger. Following the discovery of the tubercle bacillus in 1882, Coats (1886) was the first to demonstrate the organism in the gastric lesion. Musser, in 1890, was the first in America to demonstrate the tubercle bacillus in a tuberculous ulcer of the stomach.

By 1897 sufficient cases had been reported to invite reviews of the literature at the same time new cases were added. Thus in this year Hamilton reported three new cases and collected 24 from the literature. In 1898 Blumer reported a single case and collected 30 authentic cases. Arloing, in 1902, collected 146 cases in addition to his own. Ricard and Chevrier in 1905 collected 107 cases, including four of their own. Broders, in 1917, in an exhaustive and critical review of the literature, collected a total of 306 cases and added one from the Mayo clinic.

**FREQUENCY.** The actual frequency of tuberculosis of the stomach, if our standards are at all rigid, is less than the number of collected cases implies. Arloing and Ricard & Chevrier have both been criticised for their laxity in the acceptance of objectionable cases. Broders on the basis of authenticity has divided his collected cases into four classes: positive, probable, doubtful and rejected. The positive cases include

those with tubercle bacilli in the depth of the gastric lesion; the probable cases have a tuberculous histology; the doubtful cases present a good gross tuberculous picture only; the rejected cases fail to meet the qualifications of the three preceding classes as in reports with only a clinical diagnosis. Scrutinized in this way, Broders found in the literature only 49 positive and 118 probable cases while 59 were doubtful and 80 were rejected. Thus up to 1917 there were only about 167 acceptable cases of tuberculosis of the stomach in the literature.

The relative frequency of tuberculosis of the stomach is indicated in autopsy records. Glaubitt, in 12,528 autopsies, found .38 per cent. instances of gastric tuberculosis. Of the total number, 2,237 were tuberculous subjects and of these 2.1 per cent. exhibit tuberculosis of the stomach. Claytor and Wilkinson in a summary of 7,169 autopsies on tuberculous patients found .7 per cent. cases of tuberculosis of the stomach. It is not quite clear whether this percentage refers to tuberculous ulcer only or all instances of tuberculosis of the stomach. Melchior examined the stomach for tuberculosis in 1,459 cadavers, 848 of which were adult consumptives. Among the consumptives, he found six examples of tuberculous ulcers, an incidence of .4 per cent. of the total number and .7 per cent. of the tuberculous subjects. Gossman, in 5,900 necropsies at the Munich Hospital, 1900 to 1912, found evidences of tuberculosis in 40 per cent. of the subjects. But tuberculous ulceration of the stomach was present in only .31 per cent. of all cases and .76 per cent. of the tuberculous. These statistics run rather close and suggest that from .3 to .4 per cent. of all cases and about .7 per cent. of tuberculous subjects show tuberculosis of the stomach.

The general view seems to be that gastric tuberculosis is more common in adults than children. Arloing found an incidence of 1.7 per cent. among tuberculous children as against .45 per cent. in tuberculous adults, but yet believes that the condition is more frequent in adults. Broders, among his 167 acceptable cases of tuberculosis of the stomach, found a predominance of adults over children in the proportion of about three to one. The same author found the ratio of males to females two to one.

IMMUNITY. It is plain from the figures of frequency that the stomach possesses a notable immunity to tuberculosis. This



is more striking when we consider that intestinal tuberculosis is the most frequent of all tuberculous complications in the consumptive, that the stomach and intestinal walls have structurally so many points of similarity and that the stomach is essentially the passage-way by which the tuberculous lung discharges (sputum) reach and infect the intestine.

To what is gastric immunity due? Is it the acid gastric secretion? Numerous experiments by Falk, Frank, Wesener, Zagari, Strauss and Wcertz, Cadeac and Bournay and Carriere on the bactericidal effect of gastric juice on tubercle bacilli proved its inefficiency in this respect. Protracted contact, over 12 to 24 hours, attenuated but did not kill the bacilli. Struppler claimed intact epithelium was a relative but not an absolute protection. Kanzow believed in the protective effect of epithelium but also thought immunity depended upon the sparsity and depth of the lymphoid follicles and the relatively short stay of ingesta in the stomach. Klebs was also of the opinion that immunity depended on the scarcity and depth of the lymph follicles. These observers evidently believed, with Barbacci, that the follicles were the primary seat of infection. In catarrhal gastritis, the lymph follicles are increased but the tendency to tuberculosis of the organ does not seem to be greater. Wilms thinks the lymph follicles have nothing to do with tuberculosis and cites a case of tuberculosis of the stomach in a child of an age at which the follicles are few. The short stay of ingesta in the stomach might be a factor and Duerck and Oberndorfer and Curschmann consider gastric motility an important protective agency. Secondary alteration of the gastric secretion associated with delayed motility may play a part as suggested by Simmonds. All these theories and deductions from experimental and clinical data have really not cleared the matter up and the immunity of the stomach to tuberculosis remains satisfactorily unexplained.

AVENUES OF INFECTION. There are four possible routes of infection by which tuberculosis of the stomach may be established, namely: (1) Direct infection through the mucosa; (2) through the blood stream; (3) by continuity and contiguity of structure; (4) through the lymphatics.

The situation with regard to direct infection through the mucosa seems to be that, instead of offering it as a likely or possible atrium, we are put to explaining why, in spite of the frequent passage through the stomach of tubercle bacilli con-

taining sputum, the patient does not oftener contract tuberculosis of the organ. This, in fact, is what is usually done in discussing gastric immunity, for arguments on the matter usually assume infection should occur by this avenue and almost ignore other possibilities. We may not be able to satisfactorily explain why gastric tuberculosis does not occur in this way but opinion seems to be pretty uniform infection through the mucosa is doubtful or at least very infrequent in occurrence.

Infection through the blood stream has its principal advocate in Arloing whose opinion is supported by his experimental evidence, and who believes that the hematogenous is the common route. In a number of experiments, Arloing was only twice successful in producing a tuberculous gastric ulcer and in both instances the tubercle bacilli had been injected into the blood, though in one case there had also been an injection into the gastric wall as well. This mode of infection is the route of necessity in general miliary tuberculosis and Simmonds and Frerich have noted that tuberculosis of the stomach is more common in this type of tuberculosis than in the chronic forms. Wilms also thinks that gastric lesions of hematogenous origin are not so rare. On the other hand, the majority of observers and the mass of evidence do not favor the blood stream route.

Continuity or contiguity of structure is the mode of infection in a vast majority of cases according to Winternitz, who includes in this class cases exhibiting adhesions to neighboring organs, massed and adherent lymph glands and tuberculous peritonitis. Our own case is illustrative of this type of infection. Chiari, Clayton and Wilkinson, Hamilton, Winternitz, Ruge, Rosset report type cases. Tuberculous infection of the stomach from without then is much more frequent than from within through the mucosa. There is, however, some difference in opinion in the interpretation of this external attack.

This difference is well developed in an excellent article by Dewey who, in reporting a case of his own, emphasizes the plausibility of a lymphogenous origin in tuberculosis of the stomach. He shows that there is a very extensive communication between the lymphatic system of the pleural and peritoneal surface of the same half of the diaphragm and that the arrangement is particularly suitable to the spread of morbid processes from one body cavity to the other. He believes, with

Rosset, that many cases showing massed caseous tuberculous glands surrounding and adherent to the stomach are not examples of infection through continuity and contiguity but really through lymphatic channels. Perusal of Dewey's paper impresses one with the advisability of discriminating more carefully between cases of apparent direct external infection and those of possible lymphogenous origin.

PRIMARY OR SECONDARY INFECTION. If the tubercle bacillus were a frequent or even an uncommon invader of the gastric mucous membrane, there could hardly fail to be many instances of its lodgment and growth in the stomach wall with a resultant tuberculous lesion. Now the number of cases of gastric tuberculosis in proportion to the great number of consumptives is infinitely small and the best evidence we have that the gastric mucosa is seldom the avenue of infection when the stomach is involved. The importance of this lies in the fact that to establish a primary tuberculosis of the stomach it is practically necessary for the tubercle bacillus to enter through the gastric mucous membrane in a case without pulmonary, intestinal or other tuberculous lesion in the body. Thus lodging in the stomach it might set up a gastric lesion with later involvement of the corresponding lymphatic glands. Such a case would be unquestionably acceptable as a primary infection but no such instance has been reported.

In the very great majority of cases tuberculosis of the stomach is one of the final or complicating lesions of extensive tuberculosis involving many organs, notably, of course, the lungs. In Broder's 167 acceptable cases, the lungs were affected in 136 instances, were unaffected in 7 instances and were not mentioned in the history in 24 reports. Besnier, Pauliki, Hattute, Cazin, Lava, Orlandi, Kanzow, Margarucci and Ruge cite cases in which the lungs were uninvolved. In most of these cases, there were marked abdominal lesions especially peritonitis. In several of these reports, the claim is made for a primary gastric infection basing it upon the assumption that the older process was in the stomach. The same claim is made by Fischer-DeFoy in his case in which there was also lung involvement. The multiplicity of lesions in these cases almost precludes a good argument for primary infection. The two reports that present the best evidence for primary gastric tuberculosis are those of Orlandi and Van Wart. Orlandi's case had a pyloric ulcer histologically tuberculous



and caseation of the neighboring lymph glands and apparently no other tuberculous lesions. VanWart's case was one of large solitary tubercle lying between the two muscular coats of the stomach and covered by a perfectly intact mucosa. He demonstrated tubercle bacilli in the gastric lesion and there was no other definite tuberculous lesion, although the patient had a multiple serositis. This latter fact throws some doubt on his case.

If primary tuberculosis of the stomach occurs, therefore, it is so rare as to be negligible. The great majority of cases are secondary to tuberculosis of the lungs. Some are secondary to abdominal tuberculosis without involvement of the lungs. Multiplicity of lesions throughout the body is the rule.

**PATHOLOGIC ANATOMY.** The common lesion reported is the ulcer, single or multiple. About 80 per cent. of Broder's 167 acceptable cases were examples of tuberculous ulcer. A number of them were accompanied by miliary tubercle and nodules. They are more commonly multiple than single though inequality of size usually features a large single ulcer. The ulcerous lesion is irregular in outline and presents an elevated, undermined and thickened margin surrounding a rough base. Tubercles may be seen on the floor or in the neighborhood. Size varies from those barely perceptible up to 10 or 20 cm. Ten of Broder's 135 ulcerous cases had perforated. The case we report is one of perforation.

Miliary tubercles and nodules are common along with ulcer but there may be an eruption of miliary tubercles as part of a general miliary tuberculosis, and Wilms and Simmonds emphasize this lesion. Wilms calls attention to the fact that post-mortem changes may quickly obscure these gastric lesions in cases of general tuberculosis.

Finally there are some rarer types of lesions such as tumor nodules from confluent tubercle, pyloric stenosis with ulcerous contractions, lymphangitis as illustrated in Dewey's case and solitary tubercle as typified in Van Wart's case.

The enlargement of the lymphatic glands in the neighborhood of the stomach may be marked or extreme. Fusion may produce a large caseous mass closely adherent to the stomach. This is of common occurrence and it is often difficult to say whether the gastric or glandular lesions are primary. It is also in such instances that the question of extension by contiguity or the lymph vessels becomes a problem.

Histologically, an authentic case must present the characteristic microscopic findings of tuberculosis. It is not likely that these findings would be misinterpreted by an experienced pathologist. Occasionally a syphilitic infiltration might confuse. Still more specific is the demonstration of the tubercle bacillus in the depths of the lesions. The presence of the tubercle bacillus on the surface of the lesion or on the mucosa is by no means conclusive as the deposit of the organisms here is naturally quite common in cases of pulmonary tuberculosis. Happel and Blumer report a case of advanced pulmonary tuberculosis complicated by peptic ulcers of the stomach. The material deposited on the surface of these non-tuberculous ulcers showed tubercle bacilli.

CLINICAL ASPECT. If tuberculosis of the stomach is pathologically rare, clinically it is almost non-existent. The reason for this is apparent when it is realized that the disease is usually a late or terminal complication in a most advanced tuberculosis, the pulmonary or general involvement completely obscuring gastric features. Or if the lungs are free and an abdominal tuberculosis exists, the aspect is usually one of tuberculous peritonitis. In either event, the gastric features, if noted, are apt to be interpreted as functional derangements so common in this infection.

Even when the gastric symptoms are prominent and the case passes to operation on this account or on suspicion of tuberculous peritonitis, the surgical survey may overlook the real condition. Claytor and Wilkinson's case was operated on the possibility of tuberculous peritonitis but the true gastric condition was not suspected. Broder's case was operated six months prior, the diagnosis made of inoperable carcinoma of the stomach and the incision closed. In the Mayo clinic, the roentgenologic and clinical diagnoses were carcinoma of the stomach and the patient was again operated, and the pyloric third of the stomach removed, evidently on the same diagnosis, though the history does not definitely state it. Histologically the tuberculous picture was characteristic and tubercle bacilli were demonstrable.

## II. TUBERCULOSIS OF THE OESOPHAGUS.

Tuberculosis of the oesophagus and of the stomach may be most properly considered together, and for the sake of con-

venient comparison, we have, in the following brief review, followed the same outline employed in discussing tuberculosis of the stomach.

**HISTORICAL.** Denonvillers, in 1837, recorded the first case of tuberculosis of the oesophagus. In 1843 Louis added six cases discovered at autopsy on 120 tuberculous subjects. By 1868, 15 cases had been reported, but between 1868 and 1878 there were no cases recorded, and in 1877 Zenker wrote, "Whether tuberculosis and tuberculous ulcers occur in the oesophagus is not yet definitely proved." The largest number of cases was reported by Mazzotti who, in two publications, described 12 cases in the lesions of all of which tubercle bacilli were demonstrated. The great majority of reports are of single cases. Of 64 publications on this subject up to 1910, five were from American sources.

**FREQUENCY.** Lockard, in his exhaustive review, states that no other organ is so seldom affected by tuberculosis as the oesophagus. Up to 1913 he found 103 cases on record. Of these he could not analyze 14; 20 were doubtful; and 69 he could, with reasonable certainty, consider tuberculous. Of 20 doubtful cases a number represented perforation of the tube by contiguous tuberculous structures without actual tuberculous involvement of the oesophagus. By combining the figures of Voelcker, Willigk, Sanger, Zerman, Louis, Frerichs, Widerhofer, Hecker and Caselmann, Lockard found the oesophagus involved only 25 times in 16,489 autopsies on tuberculous subjects. This may be compared with the frequency of gastric tuberculosis, the stomach being involved in 62 instances in 13,500 autopsies in tuberculous subjects. Rare as tuberculosis of the stomach is, these figures indicate that it is about three times as frequent as the same disease in the oesophagus.

**IMMUNITY.** The rarity of oesophageal infection contrasted with the opportunities for its occurrence emphasizes the immunity. The chances of infection through the mucosa by means of tuberculous sputum are less than in the stomach on account of the rapid transit through the tube and the stratified squamous epithelium lining it. On the other hand, if there is a protective factor in the gastric juice, this is lacking in the oesophagus. The opportunities for infection from without, however, are striking and speak for the natural immunity of the oesophagus. The frequency and extensiveness of tuberculous lung involvement, the accompanying or independent



infection of the mediastinal glands, the serous membrane inflammations all furnish within the chest a maximum of instances for extension to and involvement of the oesophagus. Yet this seldom occurs. Lack of lymphoid tissue has been suggested as a factor. Whatever the causes they are not definitely known or evaluated and the immunity of the oesophagus, as of the stomach, remains undetermined.

AVENUES OF INFECTION. Direct infection through the mucosa may occur more or less frequently, but on account of the surrounding tuberculous circumstances, it is a difficult thing to prove. Lockard was able to collect 22 instances of supposed direct inoculation by the sputum without previous injury, but he remarks that the route of infection is not always certain. All of these cases had advanced tuberculosis of the lungs with the usual complications. In addition to the preceding, there are four cases on record in which the infection of the oesophagus was apparently induced by previous injury. The presumption is these patients were infected through the sputum. Breus's patient swallowed caustic potash; Rocher's case also was injured by a potash solution. Evert's patient attempted suicide by drinking hydrochloric acid and the oesophagus of Kundrat's case was injured by taking sulphuric acid. In all these cases there were oesophageal tuberculous lesions supposedly developing after injury. Eppinger and Kraus each report a case of thrush infection of the oesophagus complicated by tuberculous ulcers. Zenker, Cordua, Edsall and Pepper and Weyeneth report a case each of cancer of the oesophagus associated with tuberculosis. In three of the cases it is presumed the carcinoma antedated the tuberculosis but in Edsall and Pepper's case the primary invasion was supposed to be tuberculous. Compared with the same combination in the stomach, we find in Lyle's paper on "Tuberculosis and Carcinoma of the Stomach," reports of five cases (Claude, Simmonds, Barchasch, Borst and Friedlander) besides his own.

Infection through the blood stream should theoretically occur as frequently in the oesophagus as in the stomach, and it may be, as in the gastric cases, that tubercles are found in proportion to the care with which they are looked for. A number of cases have been reported as examples of hematogenous infection but many of these are unsatisfactory. Cone's case reads like a genuine example, there being generalized tuberculosis with numerous non-ulcerating oesophageal tubercles, but

even in this instance there was chronic tuberculosis of the lungs.

Infection by continuity and contiguity of structure accounts for the great proportion of cases according to most observers. And this is accomplished largely by tuberculous bronchial and mediastinal lymph glands. The enlargement and caseation of these glands is, in many instances, extreme and even cases not attributed to lymph gland infection frequently give a history of tuberculous lymphadenitis. The etiologic relationship between the glands and the oesophagus is seen in the reports of perforative communications between the two. One of Bartlett's cases exhibited five fistulous openings in the oesophagus communicating with cavities in as many bronchial and mediastinal glands. Weichselbaum reports a case of multiple perforations of the tuberculous oesophagus, eight fistulas communicating with caseous glands. Our own case showed a perforation opening into immensely enlarged and closely adherent mediastinal glands. Another source of external contiguous infection is tuberculous vertebrae. Lockard mentions seven cases of caries of the vertebrae in which the tuberculous abscess had perforated the oesophagus. There may also be direct continuous extension from the pharynx and larynx. Beck, Birch-Hirschgeld, Orth, Noder, Caselmann and Lockard report patients with tuberculosis of the pharynx or larynx or both with continuation of process into the upper oesophagus.

Infection through the lymph vessels may be the real route of infection in apparent contiguous inoculation from adherent lymph glands, as Dewey claims for gastric infection. The idea with regard to the oesophagus has received little study as yet.

**PRIMARY OR SECONDARY INFECTION.** There is no case of primary oesophageal tuberculosis in man on record. Theoretically, it is possible for tubercle bacilli to pierce the epithelium of the gullet and establish a primary infection and S. G. Shattock, before the London Pathological Society, in 1902, showed what he claimed as a primary tuberculosis of the oesophagus in a python. Practically, primary human oesophageal tuberculosis does not occur.

All recorded cases of this infection are secondary. As far as we can ascertain, every case exhibited tuberculosis of the lungs and in a majority of cases of the most advanced character with similar involvement of other major organs and vis-

ceral glands. The marked lesions of the mediastinal glands and their etiologic relationship to the oesophageal infection have already been commented on.

**PATHOLOGIC ANATOMY.** As in gastric tuberculosis, the common lesion reported in oesophageal tuberculosis is the ulcer. This and the frequently mentioned perforation are explained when we reflect that the oesophageal involvement occurs from without through the greatly enlarged and attached tuberculous lymph glands which undermine and perforate the gullet. Occasionally the perforative ulcer results from the extension from vertebral caries. Or it may be by continuity from laryngeal and pharyngeal tuberculous ulceration. Miliary tubercles and small confluent caseous lesions may be found about the ulcer and later themselves ulcerate. Multiple ulcers are not uncommon. Rarely, as in Cone's hematogenous case, there are tubercles without ulceration. In Lockard's series, there were five cases of true traction diverticula.

Microscopically, single and confluent tubercles and small and large caseous areas are seen with and without giant cells. Tubercle bacilli have been demonstrated in many cases.

**CLINICAL ASPECT.** Tuberculosis of the oesophagus is nearly always a terminal or late complication of the most advanced lung and visceral tuberculosis and up to late has had no clinical side, though occasionally it has been suspected on account of unexplained dysphagia and in a few cases actually diagnosed. The use of the oesophagoscope permits a direct and more or less exact diagnosis, but from another point of view only confirms the hopelessness of these advanced cases. Even with extensive oesophageal lesions, there may be few or no symptoms; or they may be masked by outstanding lesions of the lungs and other viscera.

As a contribution to the foregoing subject, we wish to add the following:

**CASE REPORT.**—H. R., male negro, 26 years of age, was admitted to the Philadelphia General Hospital May 19, 1919, complaining of a cold on the chest and pain in the left side.

His family history was excellent. His father, mother and four sisters are living. One sister died of broncho-pneumonia at three years of age. No history of tuberculosis in the family. The patient himself only recalled an attack of measles.

The present illness began March 1, 1919, with cough,



pain in back and left side and cold in the head. Patient continued to work until about May 13th, when he became much worse, with severe cough and expectoration, chills and fever, night sweats, sharp pain in the left side on taking a breath, and swelling of the feet. On May 19th physical examination revealed a well developed and apparently well nourished colored man. Eyes, nose and ears negative. Mouth showed a slight pyorrhea alveolaris; tongue clean. There was a well developed, muscular chest. At the right clavicle, there was a soft movable, painless mass about the size of a dollar. The heart was somewhat enlarged to the left. There was some limitation of the respiratory movements and tactile fremitus was increased over the right side. There was dullness over the lower portion of the left chest, but the right lung was apparently normal. The blood pressure was 95 mm. systolic. The laboratory reported no tubercle bacilli in the sputum and a negative Wassermann reaction.

On June 26th, the Roentgenologist reported involvement of the entire left chest. On July 2nd, an exploratory puncture of the left chest was done and a cloudy fluid containing fibrin threads was withdrawn. Laboratory examination of this fluid showed pneumococci and streptococci and pus cells. Attempts to aspirate were unsuccessful owing to plugging of the needle with fibrin. The patient's temperature exhibited daily variations from 96 F. in the morning to 104 F. at night; the pulse ran 90 to 140; and the respirations 20 to 50. He had profuse night sweats, was sleepless and was rapidly losing strength.

On July 9th he was removed to the surgical ward and a thoracotomy was done. Part of a rib was removed but no pus was found. The lung gave one the impression of consolidation. The wound later discharged freely. On July 21st the patient was examined by Dr. Walsh who made a diagnosis of pneumothorax. He died the same day.

At the *autopsy*, the anatomic diagnosis was left pyopneumothorax, both spontaneous and artificial. Tuberculosis of the left lung with cavity formation, fibrosis, bronchiectasis and tuberculous pneumonia. Mediastinal tuberculous lymphadenitis. Tuberculous ulcerations of the oesophagus with perforation. Tuberculous ulceration of the stomach with perforation. Nodular tuberculosis of the liver, spleen and kidneys. Tuberculosis of glands of the upper abdomen.

The glands of the mediastinum were much enlarged, soft and caseous. Just above the ascending arch of the aorta, a mass of glands, 6 to 7 cm. in diameter, protruded into the right pleura. Below, masses of glands filled the mediastinum

down to the diaphragm and protruded into the left pleura. In the lower half of the mediastinum the glands were fused and adherent to the oesophagus. On opening the oesophagus, a number of small ulcerations were exposed and just above the cardiac orifice there was an ulcerous perforation 1.5 by 1 cm. The oesophageal perforation opened into an adherent caseous lymph gland.

A few centimeters to the left of the cardia on the anterior wall of the stomach, just below the lesser curvature, a perforating gastric ulcer, 2 by 1 cm., sealed off by adhesions to the under surface of the left lobe of the liver. Posterior to the ulcer the wall of the stomach was caked with large, adherent, caseous lymph glands which extended toward the oesophagus on the one hand and on the other toward a large mass of caseous lymph glands around the head of the pancreas. The rest of the stomach showed no gross distinctive change.

The intestine was without tuberculous ulcerations. The mesenteric glands were but slightly enlarged. The peritoneum in general was normal. The right lung was free of tuberculosis.

Microscopic examination was made of both oesophagus and stomach at the edge and in the immediate neighborhood of the ulcers. Both parts showed a characteristic tuberculous histology of lymphocytic and epithelioid cell infiltration, giant cell formation and coagulation necrosis and caseation. The submucosa was the principal site of involvement, the muscle suffering little. A few celloidin sections were stained for tubercle bacilli without success.

This case, like the majority of this type, presented no clinical side. As far as we know, the condition of the oesophagus and stomach was not even suspected. The hospital notes gave no hint of dysphagia or gastric distress and this is remarkable in view of the magnitude of the stomach lesion. It may, however, have been masked by the stupidity of the patient or the overwhelming aspect of the pleural conditions.

The impressive features of the necropsy were the tuberculous lymphadenitis of the mediastinum and upper abdomen with its maximum glandular enlargement and degeneration, the limitation of the tuberculous lesions to the left pleura and lung with entire freedom of the right side, the escape of the intestines and peritoneum and the double perforative ulceration of oesophagus and stomach. The composite autopsy

picture with the relations of the fused adherent lymph glands to the ulcers of the gullet and stomach observed in situ, convinced us that there was no doubt as to the secondary involvement of these parts by continuous and contiguous extension from the lymph nodes. Histologically, there was no question as to the tuberculous nature of the lesion, even though tubercle bacilli were not demonstrated.

Rare as either tuberculosis of the stomach or oesophagus is, the combination of the two is still rarer and warrant the report of a single case. We wish to thank Dr. W. M. L. Coplin for permission to report this case from his service. We also wish to acknowledge our special indebtedness to Drs. Broders and Lockard from whose reviews we have drawn freely for information on this subject.

#### SUMMARY.

Tuberculous infections of the stomach and oesophagus are very rare, there being probably less than 200 acceptable cases of the former and 100 of the latter on record. An acceptable case is one which presents a typic histologic picture of tuberculosis or of tubercle bacilli in the depths of the lesion. Many theories have been advanced, but the immunity of these parts has not yet been satisfactorily explained. Practically all cases are secondary, the vast majority being infected by continuity and contiguity of structure. The common lesion of reported cases of both the stomach and the oesophagus is the tuberculous ulcer. The clinical side of these diseases is almost non-existent, due to the fact that the involvement is a terminal event symptomatically overwhelmed by obtrusive, advanced, tuberculous lesions of the chest or abdomen. A case showing tuberculous ulcers of both stomach and oesophagus is herewith reported.

#### REFERENCES.

##### TUBERCULOSIS OF THE STOMACH.

- Andral G.: Clinique Medicale, Paris, 1834, ii, 201.  
Andral & Cruveilheir: Cited by Claytor & Wilkinson, loc. cit.  
Arloing F.: These de Lyon, 1902.  
Barbacci O.: Centralbl. f. path. anat, i. Cited by Ricard & Chevrier, loc. cit. ii.  
Barkhausen: Nye hygea of otto. Copenhagen, 1824. Cited by Arloing, loc. cit.  
Besnier: Bull. Soc. anat. de Paris, 1866, p. 97.



- Bignon: Bull. Soc. anat. de Paris, 1853.  
 Blumer G.: Albany Med. Ann., 1898, xix, 145.  
 Breus: Wien. med. Wchnschr., 1878, xxviii, 11, 258.  
 Broders A. C.: Surg., Gynec & Obst., 1917, xxv, 490.  
 Cadeac & Bournay: Compt. rend. Soc. de biol., 1893, p. 599.  
 Carriere: Compt. rend. Soc. de biol., 1901, p. 1098.  
 Cazin: Soc. med. des hop., Paris, 1880.  
 Chiari H.: Wien. med. Wchnschr., 1878, xxi, 650.  
 Claytor & Wilkinson: Arch. Int. Med., 1908, i, 285.  
 Coats J.: Glasgow Med. Jour. 1886, xxvi, 53.  
 Curschmann H.: Beitr. z. Klin. d. Tuberk., 1903-4, ii, 127.  
 Dewey K. W.: Jour. Infect. Dis., 1913, xii, 236.  
 Duerck & Oberndorfer: Ergebn. d. allg. Path. u. pathol. Anat. d. Menschen u. d. Tiere, 1899, vi, 367.  
 Eppinger: Prag. med. Wchnschr., 1881 vi., 501.  
 Falk: Arch. f. path. Anat., 1883, xciii, 177.  
 Fischer-DeFoy W.: Centralbl. f. allg. Pathol. u. path. Anat., 1906, xvii, 4.  
 Frank E.: Deutsch. med. Wchnschr., 1884, x, 309.  
 Frerichs E. F. T.: Beitrage zur Lehre von der Tuberkulose, Marburg: 1882, p. 95.  
 Glaubitt: Inaugural Dissertation, Kiel, 1901.  
 Gossman: J. R.: Mitt. a. d. Grenzgeb. d. Med. u. Chir., 1913, xxvi, 771.  
 Hamilton H.: Bull. Johns Hopkins Hosp., 1897, viii, 75.  
 Happel & Blumer: Albany Med. Ann., 1898, xix, 594.  
 Hattute: Gaz. d. hop. 1874, No. 108.  
 Lava G.: Gazz. med. di Torino, 1893, xlv, 915.  
 Litten E.: Arch. f. path. Anat., 1876, lxvii, 615.  
 Kanzow: Inaugural Dissertation, Munich, 1895.  
 Klebs E.: Centralbl. f. Bakteriologie, 1896, xx, 488.  
 Margarucci O.: Policlin. Roma, 1898, v, 75 and 228.  
 Melchior L.: Beitr. z. klin. d. Tuberk., 1913, xxvi.  
 Musser J. H.: Phila. Hosp. Rep., 1890, i, 117.  
 Orlandi: Gazz. med. di Torino, 1893, xlv, 33.  
 Paulicki: Berl. klin. Wchnschr., 1867, p. 349.  
 Ricard & Chevrier: Rev. de chir., 1905, i, 557, 736; ii, 74.  
 Rosset W.: Inaugural Dissertation, Freiburg i. B., 1903.  
 Ruge: Beitr. z. Klin. d. Tuberk., 1904-5, iii, 191.  
 Simmonds M.: Muenchen. med. Wchnschr., 1900, xlvii, 317.  
 Straus & Wuertz: Arch. de med. exper. et d'anat. path., 1889, p. 370.  
 Struppler T.: Ztschr. f. Tuberk. u. Heilstaettenw., 1900-1, i, 206 and 311.  
 Talamon C.: Progres med., 1879, vii, 46.  
 Van Wart, R. M.: Bull. Johns Hopkins Hosp., 1903, xiv, 235.  
 Wesener: Inaugural Dissertation, Freiburg i. B., 1885, 55.  
 Wilms M.: Centralbl. f. allg. Path. u. path. Snat., 1897, viii, 783.  
 Winternitz, M. C.: Bull. Johns Hopkins Hosp.; 1908, xix, 223.  
 Zagari: Gior. internaz. d. sc. med. 1889, xi, 641.

## TUBERCULOSIS OF THE OESOPHAGUS.

- Barchasch P.: Beitr. z. Klin. d. Tuberk., 1907, viii.  
 Bartlett: Ann. Otol. Rhin and Laryngol., 1899, viii.  
 Beck: Prag. med. Wchnschr., 1884, No. 35.  
 Breus: Wien. med. Wchnschr., 1878, xi, 258.  
 Birch-Hirschfeld: Lehrbuch der path. Anat., 1887, Vol. 2, 518.  
 Borst: Cited by Lyle, loc. cit.  
 Caselmann: Sekundare Oesoph. Tuberk., Erlanger, 1905.  
 Claude H.: Seances et Memoires de la Soc. de Biol., 1899. Cited by Lyle, loc. cit.  
 Cone, C.: Johns Hopkins Hosp. Rep., 1900, ix, 877.  
 Cordua: Arbeiten aus den path. Institute, Gottingen, 1893, 147.  
 Denonvilliers: Bull. Soc. anat. de Paris, 1837.  
 Edsall & Pepper: A. M. Jour. Med. Sc., 1897, cxiv, 44.

- Eppinger: *Prag. med. Wchnschr.*, 1881, vi, 501.  
 Evert: *Tuberculose des Esoph.*, Berne, 1906.  
 Frerichs, E. F. T.: *Beitrage ur Lehre von der Tuberculose*, Marburg, 1882, p. 95.  
 Freidlander, C.: *Fortschr. d. Med.*, 1885, iii, 307. Cited by Lyle, loc. cit.  
 Hecker, R.: *Muenchen med. Wchnschr.*, 1894, xli, 391.  
 Kraus: *Nothnagel's Spez. Path. u. Ther.*, 1902, xvi, 214.  
 Lockard, L. B.: *Laryngoscope*, 1913, xxiii, 561.  
 Louis: *Recherches anatomiques pathologiques*, 1843.  
 Lyle, H. H. M.: *Am. Jour. Med. Sc.*, 1913, cxlv, 691.  
 Kundrat: *Trans. London Path. Soc.*, 1884, xxxvi.  
 Mazzotti: *Rivista clinica di Bologna*, 1885, January.  
 Mazzotti: *Bull. di Scienza med. di Bologna*, 1896, vii, 553.  
 Noder: *Ueber Tuberk. des Esoph.*, Muenchen, 1903.  
 Orth: *Lehrbuch des. Spez. Path.*, 1887.  
 Rocher: *Jour. de med. de Bordeaux*, 1904, xxxiv, 649.  
 Sanger: *Leipzig Path. Institute*, 1879.  
 Shattock, S. G.: *Trans. London Path. Soc.*, 1902. Cited by Lockard, loc. cit.  
 Simmonds, M.: *Muenchen. med. Wchnschr.*, 1900, lxvii, 317. Cited by Lyle, loc. cit.  
 Weichselbaum: *Wien. med. Wchnschr.*, 1884, 5-6.  
 Weyeneth, C.: *Inaugural Dissertation*, Zurich, 1900.  
 Widerhofer, H.: *Gerhardt's Handbuch der Kinderkrankheiten*, 1880, iv, 341.  
 Willigk: *Prag. Vierteljahrschr.*, 1856, xiii, 2.  
 Voelcker: *Trans. London Path. Soc.*, 1890, Vol. 42.  
 Zemann: Cited by Lockard, loc. cit.  
 Zenker: *Deutsch. Arch. f. Klin. Med.*, 1891, xlvii, 191.  
 Zenker: *Deutsch. Arch. f. Klin. Med.*, 1895, lv, 405.

## CONSERVATIVE TONSIL SURGERY.

BY

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(Read by Title before the Homœopathic Medical Society of Pennsylvania.)

At the July examinations held by the Pennsylvania State Bureau of Medical Education and Licensure the following question was asked the applicants: "On what general symptoms and on what conditions in the tonsils would you advise enucleation of the tonsils?" Following is an incomplete list of the many conditions and symptoms enumerated in the answers:

Endocarditis; rheumatic fever; chronic rheumatism; arthritis deformans; cervical adenitis; undernourished children; furunculosis; incontinence of urine, slow growth, dullness in school; catches cold easily; fever of unknown origin; pains in the back or in muscles without cause; stomach disorders; slowness of thought and impaired mentality; listlessness, awakens tired in the morning; appendicitis; cholecystitis; nephritis;

muscular spasms; middle ear diseases; early tuberculosis; general infection; intercostal neuralgia; septicaemia, gastritis; defects of speech, taste and smell. Progressive secondary anaemia: Chorea; uveal inflammation (my experience is that uveal inflammation, when due to focal infection is usually from an accessory sinus); eczema, constipation, rachitis, asthma, Vincent's angina, anorexia, weakness, loss of weight, precordial pains, chronic rhinitis, chronic bronchitis, chronic gastritis (this is one answer). Anaemia, exophthalmic goitre and other goitres, pericarditis, endocarditis and myocarditis, myositis ossificans, menorrhagia, chorea, tuberculosis, cystitis, chronic indigestion, cholecystitis, neuritis, nephritis, acute arthritis, rheumatic arthritis, osteomyelitis (is not that a gem, about the only condition omitted in that answer was ectopic pregnancy.)

In addition to these general conditions, of course all possible local conditions in the tonsils were mentioned, even including sarcoma. A few stated that the tonsils should be removed in all diphtheria carriers, yet most of the answers omitted the value of removing the tonsils in streptococci carriers, one of the most important indications.

On reading the answers to this question, I was convinced that a tonsil would not have been safe under any conditions in that examination room, or with that particular crowd of young doctors. Now, where did they get this "dope," these indications? Was it from the professors and lecturers on rhinology during their college course, or from clinical instructors during their intern service, or from collateral reading? Many definitely stated that they would remove the tonsils in such physical conditions as enumerated "if no other positive focus of infection were found," evidently on the chance that they were the offending cause, even if apparently normal. A very few advised an examination of the tonsils in cases of suspected focal infection; possibly many others took such an examination for granted. However, the general idea seemed to be to enucleate all tonsils and the annihilation of the human tonsil seems now to be assured, for these young doctors will surely practice what they have been taught. The physiology of the tonsil meant but little to them.

Two main offending factors in the indiscriminate removal of tonsils may be considered—the clinics and the visiting school doctors. The school doctors do not have an opportunity for



extensive examinations, and they send many children home with the suggestion that their tonsils be removed, instead of advice to have their tonsils examined. So the clinics get many of these children as well as others, many of them coming to the operating table without the surgeon ever having made a previous examination, local or otherwise. The rhinologist in his private practice uses more discrimination.

The writer has no thought or intention of underrating the importance of focal infection as an etiological factor in many conditions, nor to minimize the absolute necessity for the enucleation of the tonsils in many such cases; *but*, for the sake of suffering humanity, *trace* the focus to the *tonsil* before removing it. Do not treat the tonsil as a gland or a piece of tissue of no value in the human body, just because its physiology is rather vague. Dr. Chevalier Jackson, in his lectures on rhinology uses an apt phrase quoted by some of the applicants, "a normal tonsil is a safeguard to infection, a diseased one is a cesspool for bacteria."

The following is one of the best answers given at the examination, to my mind: "Repeated attacks of tonsilitis, especially when associated with joint symptoms. Heart diseases when due to acute rheumatic fever with tonsillar involvement. Rheumatic conditions of idiopathic origin where tonsils are diseased. Mouth breathing when due to excessive hypertrophy of the tonsils, and also interference with the hearing from the same cause. Imbedded cryptic and hypertrophied tonsils are always a menace and should be carefully watched, however, the wholesale removal of simply enlarged tonsils is a mistake. When the ducts are not clogged they are able to care for themselves in a majority of cases."

At the June meeting of the Ophthalmological, Otological and Laryngological Society at Asbury Park, considerable discussion was given to tonsil surgery, especially following reports from military surgeons in relation to their studies on the subject of throat infection. As these investigations could be made upon a large number of men living under similar conditions, and could be checked up fairly accurately they were of great interest and importance. One report particularly interested me: In a certain army camp, all the men in one company, about 130, had their throats examined bacteriologically: 80 per cent. were found to be streptococci carriers, or had streptococcic infection. All of these men had their tonsils

removed, and yet about 21 per cent. still had streptococci in their throats after operation. In line with this, recent investigators found streptococci carriers with hemolytic strep. in their post-nasal spaces, evidently due to drainage from accessory nasal sinuses, particularly the ethmoid sinus.

Another interesting report was of a case of severe tonsillitis; of course, the tonsils could not be removed during the acute inflammatory stage; the patient developed endocarditis and died; on post-mortem hemolytic streptococci were found on the heart valves. I have recently seen a somewhat similar case, in which following within a week of the first attack of tonsillitis the child ever had there developed a severe attack of rheumatic fever with two badly damaged heart valves, and a very poor prognosis.

Have you ever encountered the fact that in quite a few cases of tonsillectomy latent rheumatism has been brought into reactively, due to there being other foci (in the joints) inactive at the time of operation? Dr. DeSchweinitz calls attention to this practical point, "That the removal of septic tonsils is sometimes followed by an exacerbation of the associated ocular disease." He further suggests, "That it is quite possible that during enucleation of the tonsils some additional septic material was liberated which was responsible for the increased virulence of the uveitis," and, "That a similar increase in arthritic symptoms sometimes follows tonsillectomy." The writer is inclined to agree fully, and has heard operators in other cities cite cases of recurrence of arthritic conditions after tonsil operation.

Where there is an absolutely clean enucleation without a cut in the tonsillar tissue there should be less chance of this occurring, but even at that if the bacteria loaded crypts squeeze out their contents during operation, as they often do, there is much chance of some bacteria getting into the blood stream. The use of the new apparatus which sucks out all blood, mucus and detritus from the throat during operation is of distinct value.

Do not forget that even if focal infection is the cause of bodily disease or symptoms that the fault does not of necessity lie in the tonsils. The teeth and the accessory nasal sinuses are often at fault and should be investigated. Do you think it fair even to say that, "If there is no other focus of infection to be found, remove the tonsils?" Would you sacrifice a tooth

or a lot of teeth without an examination, including a radiograph? And yet the teeth are known and proven to be definite foci of infection in many cases, even in fevers of obscure origin, which formerly were all blamed on the tonsils. A clinician recently told me of two cases of tinnitus aurium, which had failed to respond to local treatment to the ears, which were cured by dental work on imbedded unerupted wisdom teeth.

Dr. DeSchweinitz has an interesting excerpt on "Uveitis." "The notable advance in our knowledge within the past four or five years throws an entirely new light on the etiology of uveitis. Rheumatic iritis has almost disappeared from our classification of iritis," (personally the writer was always disappointed in rheumatism as a factor in iritis, and with treatment based on such etiology), and, he goes on, "Chronic rheumatism has given way to focal infection. The patient gets an inflammation of the uveal tract, not because he has rheumatism in the strict sense of the term, but because his uveitis is a manifestation of toxemia coming from the infection of which he is subject and his muscle, joint, and fibrous pains and lesions are but other manifestations of the same cause. It is probable that almost every case of inflammation of the uveal tract is of septic origin, either a focal infection from the teeth, the tonsils or accessory sinuses."

A recent case of my own gave me food for much thought. The patient has rheumatism when a child, and had a severe attack of septic endocarditis following typhoid fever at the age of twelve years which left her with mitral heart trouble; the heart muscle, however, got in fine shape, and she outgrew her dyspnoea, compensation was perfect, she was a big healthy girl. At the age of 24 she developed rheumatism (apparently) in both feet, both ankles and one hip. Medical treatment and hydrotherapy failed to relieve, and her tonsils were removed, a clean complete enucleation. The tonsils were quite a bit hypertrophied but not diseased, the crypts did not squeeze out any deposit, but no bacteriological examination was made. The rheumatism got worse and a cough developed with fever—skiagraphy of her lungs showed many spots of subacute activity, but there were no tubercle bacilli in her sputum. Her teeth were radiographed and several extracted, but with no improvement. Blood culture, to our surprise, showed no streptococci, but did show pneumococci of the third type. Several



month later she died from septic endocarditis. (No post-mortem was allowed by the family).

Bacteriological work in relation to the tonsils is only of recent development, nor have investigators arrived at definite conclusions as yet. The deposits in the tonsillar crypts are often found on culture to contain non-pathogenic organisms such as the micrococcus tetragenous and the diplococcus. Such cryptic collections are not causes of focal infection, while many tonsils in which the ducts are sealed up by previous inflammatory processes may contain deep in the tonsillar tissue septic bacteria and act as a foci of infection.

I am not discussing those tonsils which are so obviously diseased as to require removal without any possible thought of other treatment, but rather the search or investigation of the tonsils for a possible focus of infection. Nor do I advocate bacteriological work on all tonsils before removal, but a more frequent exploration before operation. If the ducts are sealed up, it is easy to open one deeply and remove for culture any collections found there. Bacteriological study of sequellae to tonsil operations will also be of value as a guide. My claim is that we are not justified in the removal of tonsils on suspicion even if the case seems to be due to some undiscovered focus of infection, without a thorough bacteriological as well as local examination of the tonsils.

During the summer of 1917 and later there seemed to be a spread of hemolytic streptococcic sore throat, especially in army camps, or perhaps it was more thoroughly studied in army camps. At Camp Custer, in Michigan, hemolytic strep. were recovered from the depths of 80 per cent. of tonsils examined after their removal—if there after operation, they could have been discovered before removal. Lille and Lyons report 200 cases of myositis and arthritis which had been tonsillectomized, 40 per cent. favorable, and state, "That a tonsil history is not always obtainable in these cases, a focus may be active without local signs." So they go ahead and sacrifice the other 60 per cent. of tonsils without any attempt at investigation.

After all this, you may perhaps ask my indications for the removal of tonsils. First, a thorough scrutiny of the local conditions in and around the tonsils should be made. I would advise the removal of all tonsils which are constantly showing tonsillar inflammation and so loading the system with toxins

which cause various forms of arthritis and endocarditis. Tonsils which are submerged and adherent to the pillars and are causing adjacent inflammation should be removed. All tonsils which have cryptic deposits and collections. Hypertrophied tonsils which obstruct the breathing or the eustachian tubes. In practically all cases of chronic otorrhoea. All tonsils which on bacteriological examinations show they are diphtheria or streptococci carriers. I would not advise the removal of the tonsils in very young children even if somewhat enlarged, unless obviously diseased, but instead would remove adenoids, in most such cases the obstructive symptoms to the breathing will be removed thus and the tonsils shrink back into their fossae.

Many tonsils are diseased and many tonsils are septic carriers, but be sure to study other sources of possible infection besides the crypts of the tonsils, and do not operate just because you see enlarged or submerged tonsils. The size of a tonsil is of no consequence unless it produces symptoms.

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HEMIANOPSIA AFTER TRAUMA.—As chief of the eye department of the Belgian Hospital at Havre, Rasquin had the opportunity of observing a large number of cases of hemianopsia encountered among the wounded. He classified them according as the individual requires the aid of another person, or not. He found that a gap in the visual fields is more disabling the closer it is to the point of fixation. (*Arch. Med. Belges*, Jan., 1918.)

Sarnowski has studied the cases of six soldiers who received wounds of the head, in the occipital region. He describes the effects upon the nervous system, and the modification in the visual fields which resulted. All but one of the men showed hemianopsia, and there were marked retractions of the fields. (*Clin. Opth.*, V. 22.)

Behr had two cases with injuries to the pituitary body in which the patient survived. The first case was due to a small-bore revolver bullet, which entered the right temporal region. When first seen both pupils were widely dilated and there was complete amaurosis. One month after the injury there was complete right and partial left ophthalmoplegia. She was completely blind. Six weeks after the injury the left pupil showed pseudo-paradoxic light reaction, contracting considerably after closing the lids. Pupils contracted with extreme abduction with the retinoscope when there was a fixing on near point in the left. None of these effects were seen on the right side.

In the second case a blow had been received on the head from a club. For a month after the injury there was loss of memory, alexia, and sensory aphasia, paresis of the left oculomotor nerve, and atrophy of the left optic nerve. There was a right sided hemianopsia. This improved later to a defect in the right temporal field, but left a typical bitemporal color hemianopsia with the dividing line passing through the point of fixation.—*British Journ. Opth.*, Vol. 3.

**"MAMMARY CARCINOMA."**

BY

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My subject was chosen because an interesting paper was presented to the Surgical Bureau of the American Institute of Homœopathy, at its recent meeting by Dr. Ward, of California, on this subject, which paper elicited an edifying discussion. In her paper if my memory serves me correctly, Dr. Ward emphasized the importance of early diagnosis of all breast conditions, a careful separation and classification of them, and through surgery especially for those of malignant character. Other points were brought out either by the paper or discussion, namely; the frequency of transformation of the benign growths into malignant ones, the necessity to remove lymph wells and channels, the necessity for the deep burning effect of the X-ray to sterilize the field and cure recurrences, etc.

I want to emphasize again, the importance of the early diagnosis by encouraging people with nodules, growths, lumps and so forth, to appeal for aid as soon as they discover them so that we may study the precancerous condition and then apply surgical treatment at once. The fact that men *are* studying the precancerous condition is making possible continuous improvements in technic and a great increase in the number of cures. Non-malignant tumors are very frequently found. Some one puts the percentage at 16½, and sarcomata at 2½ per cent. being about 19 per cent. of growths of the breast that are non-carcinomatous. Of first consideration is chronic mastitis or fibrous and glandular hyperplasia, with retention cysts. In these cases, hyperplasia precedes cyst formation. We cannot emphasize too strongly that these cyst-adenomata are frequently incipient cancers and should be dealt with accordingly. Various operators and investigators place the number of transformation at from ten to twenty-five per cent. No doubt the percentage of all cases, including those not investigated would be higher. Chronic mastitis is a breast condition most difficult to differentiate from carcinoma. There is less difficulty in differentiating between solid benign neoplasms and carcinoma because needle puncture



will aid in the diagnosis; but, the microscope must be used if one would be sure as to whether the growth is a cancer or a chronic mastitis with cysts.

Both conditions are likely to occur between forty or fifty years of age in women nearing the menopause. I have seen a larger number of cyst-adenomata in single than married women and in mammae that have not functionated.

A point in differentiation is that abnormal or chronic mastitis is frequently bilateral. Carcinoma is infrequently so. Abnormal involution is painful and cancer is not; at least in the first ten to twelve months of its existence, it is not. This is contrary to earlier teachings concerning pain in cancer. When adhesions to skin or muscles or when ulcerations come, cancer is painful but by that time the diagnosis is clear. Early cancer is painless and because so many diagnosticians believe it is painful, they counsel waiting. They want to await developments at a time when radical surgery would save a life that is to be lost by procrastination. The responsibility for educating the people in regard to malignant disease, rests with us. To continue with comparisons the pain of chronic mastitis is variable, being usually increased at the menstrual time when the gland is visibly enlarged. The pain is greater when pressure is made over cyst-sites. Well defined and enlarged veins may be seen under the skin of the breast; not so markedly, however, as in sarcoma. Glandular involvement occurs in both diseases but in chronic mastitis the glands are smaller and more generally painful, especially under pressure, than in cancer. In the latter condition they are larger and not painful and may be coalesced. If there be an exudate from the nipple we must consider (1) cancer, if it is sanious; (2) papillary cyst-adenomata, if pure blood, and (3) mastitis if straw color. Sometimes the discharge becomes sanious as the mastitis advances to a duct cancer. The patient finds continually a small stain of it on the garment or on the dressing. This describes Paget's disease which according to Murphy and Rodman is not primarily a disease of the skin extending inward but one beginning inside the duct and extending to the surface where the discharge irritates the skin and excoriates it. Rodman considers Paget's disease malignant, and early malignant. He claims that most of his cases suffered prompt recurrences after operation. All growths of the breast in my judgment should be operated on.

Differentiation in the character of them guides us in the determination in the kind of operations to do. The technic of operation differs according to the ideas and experiences of the operators. The complete or radical operation is to be used except in cases of benign growths or early precancerous malignant ones. Halsted advised and others still advise removal of the muscles in every case of cancer to facilitate a complete axillary operation and because the avenues of extension are between and under the muscles in the connective tissue. Murphy does not because the removal of the fascia is as far as he found it necessary to go. Rodman worked from the axilla to the sternum. Halsted and his disciples from the sternum to the axilla. Rodman's reasons for his method seem to be very logical, namely: better control of the scar, ligation of the vessels above or near their origins, thus controlling hemorrhage, the working from healthy to diseased tissue and the blocking of the lymphatics in the axilla at once, thereby preventing the migration of cancer cells. Another reason is that if the axilla is so completely involved as to make radical operations futile, the patient will be saved the risk and shock of an extensive operation as by the other plan. When there is malignancy of course the radical operation is essential, but I believe that many times the complete operation is performed upon benign or precancerous growths that could be treated conservatively with success. I heard Dr. Charles H. Mayo say that as long as a woman has her nipple and areola conserved, she does not consider herself mutilated or much disfigured by the operation, therefore, whenever possible he advises and encourages conservatism. That is, after proving by suitable and thorough scientific investigations, that a given case will respond to the treatment, the growth only is removed. He does not remove the entire gland. For three years, I have been following his plan with gratifying results to my patients and satisfaction to myself. The complete operation is so disfiguring that women who have seen the deformity following its use, on their neighbors, decide that they would rather retain their growth if it means death, than have such disfigurement.

I believe such fear deters women from having operations, or at least timely operations for these neoplasms.

Ten years ago in removing cystic growths, I operated through an incision in the line of the mammary crease with good results, but the last few years I have used a horizontal

incision at the junction of the upper and lower outer quadrants of the gland. The length of the incision depends upon the size of the breast but the smallest incision and as far outside of the areola as possible is desirable. Through this window can be removed not only the cyst or cysts but all of the functioning part of the gland, leaving only innocent fat, nipple and skin. The results are quite satisfactory because the bust form remains and also because recuperation and complete healing are rapidly accomplished. I think the patients are justified in their feeling of security and immunity after these early operations. I have been sufficiently fortunate to have not had a recurrence in the persons I have operated on. Besides the operation being done early, we accomplished the removal of the entire cancer breeding mass of the gland, with the exception possibly, of the duct stumps in the nipple. Following a unilateral or bilateral operation of this kind, the patient will feel properly dressed when wearing evening clothes. My points are; getting the information concerning breast growths, such as their insidiousness, their danger and their proper treatment, before the public more successfully than we have been doing, so as to get the early and thorough co-operation of prospective patients. Also, the early scientific differential diagnosis with **early surgery; which should be radical** in character if necessary, but conservative and plastic in effect whenever possible.

#### DISCUSSION

DR. H. L. NORTHROP, of Philadelphia, said that we should be impressed with some of the points made by Dr. Hartmann, and especially with his remark concerning the painlessness of cancer in its early stages. If we could enforce upon patients the fact that cancer does not cause pain in the beginning, we would do much to aid them in consulting the physician early so that the cancer could be removed in its incipiency. It is unfortunate that the complete breast operation is mutilating for it cannot be avoided. If cancer is present, the operation is necessarily mutilating, and the patient must submit to it. The greater and the lesser pectoral muscles are removed because we must take away the part of the gland extending upwards between these two muscles, for many surgeons have found repeatedly infected nodes between the pectoralis major and the pectoralis minor. If these infected nodes are



permitted to remain, no matter how complete the removal of the breast may be, or how extensive an area of skin has been removed, the cancer will manifest itself again in the near future. A prominent Baltimore surgeon says that he removes a large area of skin, the mammary gland, and the axillary lymph nodes, and that the surgeon who does not open the axilla in examining for cancer of the breast is criminally negligent. Such radical work is the rule, as Dr. Hartmann indicates, and that the complete operation is indicated when the disease is positively of a malignant character. If there is any doubt as to the position of the cancer, it is better to remove both the gland and the muscles and afterwards find by the microscope that the disease is not malignant, than to leave a particle of cancer behind to require another operation or to spread beyond the help of surgery before another operation can be performed.

In concluding his remarks Dr. Northrop directed attention to a line of dietetic treatment advocated by Dr. Horace Packard, of Boston, namely, the feeding of the patient who has been operated for cancer with such foods as will supply an extra quantity of salts to the body. He believes that cancer obtains as the result of modern methods of food preparation and cooking. The beautiful white flour that we like to look at, and which we think so nice, is prepared from wheat that has had the outer envelope of the grain removed by the modern processes of milling; so that what is left is little more than a starchy granule. It is the same with other foods. The cook peels the potato and soaks the food in water for half an hour before boiling. The subject peering such potatoes is deprived of the mineral salts that are so important in keeping up the nutrition of different tissues of the body. We should eat baked potatoes or those boiled in their jackets. It is the same with rice and other grains. That is an important phase of the subject, and Dr. Packard has become convinced that there is something more than theory to it; that there is a great deal of practical value in the dietetic treatment of subjects threatened with cancer, who have a cancer history in the family. We are believing to-day in the hereditary origin of cancer. We can trace it through families, and there is something to the remark of the patient who came to a physician, showed him a lump and said: "This cannot be cancer, because there is no cancer in our family." We should take these statements into account.

So this is a very burning question, and we, as surgeons, may take the advice of Dr. Hartmann and be just as radical as we can in our treatment of malignant disease.

## EDITORIAL

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### SOME OLD AND NEW REMEDIES—I. ACONITE THE NEGLECTED.

For many years the prescription of aconite by members of our school was as common in the management of acute cases as was the administration of sulphur in the chronic. When Hempel wrote his voluminous treatise on *materia medica*, he found enough virtues in that remedy to require over two hundred pages for their description. Medical students at Hahnemann in those days saw fit to call him Father Aconite. Even in more recent years aconite was a great favorite among physicians of our school, and brought such good results that its use was strongly endorsed by *materia medicists* of the old school, notably by Ringer, Phillips and Hare. At one time it was used almost as a routine drug for fever, but for some reason or other has given place to *gelsemium*, *bryonia*, *ferrum phos.* and *veratrum viride*. This editorial is prompted by our feeling that aconite has been neglected unjustifiably.

Standing, as we said, as an important remedy in fever, later becoming neglected, we believe that such neglect is the result, in part, of misinterpretation of the teaching of Farrington and others. Farrington wrote, "We find it indicated in general inflammatory fever, in what is called synochal fever, otherwise termed *sthenic* fever. All these terms apply to a fever which has about it no quality of *adynamia* or *asthenia*." Hare likewise says, "It ought not to be used in *adynamic asthenic* affections." Now, as a matter of fact, modern research has placed practically all fevers on the etiological foundation of infection. Aconite has been largely abandoned. We believe that the old indications, dry heat of the skin, full bounding pulse, restlessness, with or without attendant anxiety offer today as of years ago, reliable indications for the drug. It is unquestionably the medicine above all others for the fever of acute inflammatory diseases in their early stages. It is not, however, to be used in cases where fever is prolonged. In other words, it is a drug that secures prompt results or none at all. It is indicated in a large number of acute diseases, especially when the advent of the same is associated with chills

or chilliness. There is, of course, considerable division of opinion as to the dose of aconite; the majority of our practitioners use it in the third or lower, while many employ small doses of the mother tincture. Ringer, Phillips, Barthelow, Brunton and others of the old school employed one-half to one drop doses of the tincture every hour until results were obtained.

Notwithstanding the predominant indications for bryonia and gelsemium in the majority of cases of influenza, there were certain districts of the country in which our physicians considered that aconite was the prevailing remedy. In other words, it was the *genius epidemicus*.

As a corollary of what we have said, concerning the fever of aconite, it does not require an active imagination to make it a standard routine remedy for post-operative complications. Indeed, there are some few surgeons who prescribe it routinely immediately after operations; a practice that we think has a logical foundation.

Aconite is unquestionably an excellent regulator of the circulation. Hare says of it, "Aconite is by far the best circulatory regulator in children for sthenic fevers, particularly of the irritative type." Later he refers to it as an excellent remedy for the epistaxis of full blooded people. We believe that aconite should be accepted as one of our standard anti-hæmorrhagic remedies, and that it is far more valuable than the many "vaunted coagulines" and such remedies as hamamelis, erigeron, etc. It is unquestionably the best remedy we have for hemoptysis and should be prescribed routinely in the absence of indications to the contrary.

Aconite is not without value in acute neuritis arising from exposure to cold or traumatism.

As one of its therapeutic spheres we may call attention to its value in thermic fever to which it is symptomatically adapted, although we should not depend upon it to the exclusion of the usual hygienic measures.

Among old school physicians, aconite has also become to be grossly neglected, excepting as a component of certain prescriptions for local application and strange to say, wherein it is largely neglected by the best element of physicians. William Thomson, of New York, in his work on "Clinical Medicine," called attention to the drug as a valuable means of producing a permanent lowering of blood pressure. He advocated



doses of five to ten minims of the tincture three times daily. On several occasions, where indications favored, we have tried out Thomson's recommendation and have felt that we have secured better results than we did with the nitrites or vaso dilators.

In the main the indications for aconite as used by the old school follow closely those in vogue among the homœopaths.

In closing, we would direct attention to the alkaloid of aconite, namely, aconitin. We would here make a caution and a suggestion. The caution relates to the variations in strength or activity of the various properties of aconitin. Some are of such potency that the twentieth of a grain has caused death, while other preparations have seemed, comparatively speaking, innocuous. Hare remarks that aconitin should never be used internally, although he places the doses at one two-hundredths to one one-hundredth of a grain. Many years ago, Seguin, of New York, recommended aconitin in cases of tic douloureux. His method of procedure was to start with one two-hundredth of a grain three times daily, gradually increasing the dosage until relief was obtained or physiological action of the drug appeared, as exhibited by tingling of the finger tips. This never necessitated a greater quantity than one-hundredth of a grain three times daily. Hare, notwithstanding his warning above quoted, says full doses of Duquesnel's crystallized aconitin are of value in some cases of persistent neuralgia. We have employed aconitin as advocated by Seguin and we have obtained some good results; ultimately, however, this medical treatment fails as do all others and the patient is finally relegated to the surgeon.

We have also employed it with results, sometimes brilliant, and sometimes negative in the obstinate neuralgias following zoster. We would make the same caution as did Hare. We advise care as to the selection of aconitin, avoiding preparations that are not standard and adherent to Duquesnel's crystalline preparation.

We could say very much more in favor of aconite would space permit. Standard materia medicas of both schools testify to its efficiency. When we started these editorial remarks we thought we would finish what we had to say in the course of a page or so, but as we progressed our enthusiasm over an old friend has made us, we hope, not too prolific. The list of affections in which aconite is a possible remedy is a large one

and we could readily prolong our eulogium to an extent as to entitle it to the designation of a therapeutic review.

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### THE ENDING OF PNEUMONIA.

THE crisis in pneumonia has always remained a most fascinating fact, not only because its occurrence is anticipated; but because the reaction itself has remained a mystery. Of all the popular diseases, pneumonia is practically the only one which in about 50 per cent. of the cases terminates by crisis. Just why a disease which can suddenly assume such gravity should, on or about the seventh day suddenly end, has caused much conjecture.

The immunological explanation is too well known to need much elaboration. Cole<sup>1</sup> mentions that the crisis suggests an immune reaction because it has been shown experimentally that the antibodies appear in the blood at their maximum in about seven days. Further, the serum of patients recovering from pneumonia has a protective action for mice, against pneumococcic infection. It has also been shown that the opsonins are increased about the time of the crisis. Again, the leucocytosis, considered favorable in pneumonia, suggests that the body's combative forces of an immune nature play an important part. However, if the favorable ending of an attack of pneumonia is due to immune substances, the immunity is but of short duration, because repeated attacks are not uncommon. As a matter of fact one attack of the disease seems to leave, in many instances, a predisposition to subsequent attacks.

Recently there has appeared an explanation of the crisis in pneumonia, based upon chemistry. At first glance this more modern view seems quite tangible. It is well known that the successful artificial cultivation of bacteria depends to a great extent upon the chemical reaction of the culture medium in which they are grown. It is also known that certain organisms have the power to produce an acid in the medium in which they are grown and that this acid eventually inhibits growth. Among such organisms are pneumococci.

Avery and Cullen<sup>2</sup> have recently studied the effects of various hydrogen ion concentrations (degrees of acidity) upon

the growth of pneumococci in broth cultures. They found that the optimum hydrogen ion concentration for the growth of pneumococci is 7.8. In broth cultures they found that growth continues until a final concentration of about 5.0 is reached. This degree of acidity is sufficient to stop growth, irrespective of the immunological types of pneumococci. Lord and Nye<sup>3</sup> found that pneumococci did not survive longer than a few hours in a hydrogen ion concentration of 5.1; but in concentrations of 6.8 to 7.4 lived for days. Between the concentrations of 6.8 and 5.1 the pneumococci die with a rapidity which bears a direct relationship to the hydrogen ion concentration. The greater the acidity the more rapid the death of the bacteria.

Lord<sup>4</sup> found that in three of four cases examined, pneumonic lungs showed a greater degree of acidity than did other lungs used as controls. He<sup>5</sup> also called attention to the importance of acidosis and enzyme action in the crisis and resolution in cases of pneumonia. If the diseased region is to be regarded as an area which is in a measure isolated from other parts of the body, as Lord suggests, we can more readily understand his most recent theory of the crisis in pneumonia<sup>6</sup>. The production of acid in media by the growth of pneumococci and the acid reaction of pneumonic lungs, suggests that the crisis and recovery may be due to local bio-chemical changes, in the course of which the acid death point of pneumococci is reached. During the course of the disease a gradual increase of the hydrogen ion concentration of the exudate probably takes place.

It would seem that this chemical action only affects the organisms which are lodged in the lung and does not explain the disappearance of the bacteria from the blood stream in favorable cases. It may be that the immune bodies, regardless of their transiency, play an important part in overcoming the circulating bacteria. Generally it is found that in favorable cases the pneumococci disappear from the blood stream; while their presence there throughout the disease usually offers a grave prognosis. In other words, it seems as if their localization offers the best chance to the patient. The chemical theory, to say the least, is worthy of our attention.

Resolution has long been credited to enzyme action, digestion and absorption and Dernby<sup>7</sup> working along another line, furnishes facts which bear out this belief. Dernby showed that the exudates of liver, spleen pancreas, leucocytes and



mucous membrane of the stomach have a proteolytic enzyme which acts best in a hydrogen ion concentration of about 3.5 and can not act in an alkaline or neutral medium. This finding along with the acid state of the lung in pneumonia confirms, if it does not shed more light upon, the accepted theory of resolution.

—J. G. W.

#### REFERENCES.

1. Cole, Rufus., *Arch. Inter. Med.*, 1914, xiv, 56.
2. Avery, O. T. and Cullen, G. E., *Jour. Exp. Med.*, 1919, xxx, 359.
3. Lord, F. T. and Nye, R. N., *Jour. Exp. Med.*, 1919, xxx, 389.
4. Lord, F. T., *Jour. Amer. Med. Asso.*, 1919, lxxii, 1364.
5. Lord, F. T., *Jour. Amer. Med. Asso.*, 1916, lxvii, 1981.
6. Lord, F. T., *Jour. Exp. Med.*, 1919, xxx, 379.
7. Dernby, K. S., *Jour. Bio. Chem.*, 1918, xxxv, 179.

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### THE RELATIONSHIP OF INFANTILE ECZEMA TO DISTURBANCES OF NUTRITION.

DERMATOLOGISTS are inclined to look upon eczema as a purely local disturbance resulting from some form of local irritation or infection. It is true, irritation, whether mechanical or chemical, is frequently responsible for the appearance of an eczematous rash at the site of the irritation, but the underlying cause of the inflammatory reaction in the skin is a nutritional disturbance.

There are two types of eczema classically encountered in infancy, one presenting a bright red, moist dermatitis limited almost exclusively to the face and occurring in fat, well-nourished infants; the other presenting a dry, sluggish rash on the body and encountered in poorly nourished infants. The first type is intimately associated with overfeeding, be it breast or artificial feeding, and is, perhaps, more closely linked to fat-intolerance and fat-overfeeding than to any other element in the food. In these cases undigested and unassimilated fat in abnormal amount is usually demonstratable in the stools, and furthermore, a reduction in the amount of food and particularly in the amount of fat is followed by marked improvement in the symptoms.

The dry form of eczema is, as a rule, more rebellious to treatment. Its etiology is not so clear as the moist type. White thinks that carbohydrates, especially starch, play an important role in the etiology of this form of eczema, but this theory

has not been substantiated either by clinical proof or otherwise. The cause, no doubt, lies deeper. Some of these cases are unquestionably of constitutional origin and show definite signs of hypothyroidism. Furthermore, they improve upon the administration of thyroid extract in small doses. Others again appear to be clearly instances of anaphylaxis, the skin lesion being a manifestation of chronic protein poisoning. Hypersensitiveness to the protein of cow's milk, to egg albumin, wheat and other foreign proteins can at times be satisfactorily demonstrated in these infants with the cutaneous test. This, however, is not always successful. While the moist eczema cases usually present definite signs of the exudative diathesis and show a marked eosinophilia, the dry cases often show a leucocytosis. Such cases may be of bacteriologic origin.

The treatment of infantile eczema is, therefore, entirely symptomatic and requires the closest clinical study before a rational line of treatment can be mapped out. The dietetic management of these cases is of first importance; they are not cases for the dermatologist but for the pediatrician. The removal of all sources of local irritation and the institution of mild protective and sedative local treatment is, of course, a necessary adjuvant. Antiseptic treatment is at times also necessary, because secondary infection is a common complication in infantile eczema. Local treatment, however, occupies a purely secondary position in the treatment of infantile eczema.

Internal medication is of distinct value. Not only are nutritional disturbances present in these cases, but the blood picture is abnormal, the digestion is deranged and metabolism, especially the metabolism of the mineral salts is abnormal. For the acute symptoms such remedies as belladonna and rhus tox. have proven themselves of great value, while the diathetic abnormalities call for such remedies as arsenicum, the calceas, hepar sulph., graphites, mercurius and thyroid extract.

C. S. R.

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#### THE NEW YORK STATE HOMŒOPATHIC MEDICAL SOCIETY.

OUR State Societies, in many cases, have dropped from their point of highest efficiency during the period of the war, because, as was natural, some of their strongest workers

among the members turned from sectional matters to those of national importance and joined with all others who were 100 per cent. American in putting their efforts to winning the war.

Credit must not be taken from those who remained at home and redoubled their efforts to keep their organizations in the most efficient form possible during the trying period until the time when their fellows returned to their accustomed places.

The Homœopathic Medical Society of the State of New York has emerged from the war depression and now is in a period of distinct Renaissance.

The maintenance of the school of homœopathy is incentive, which alone should sustain our State organization, but particularly at this time it is necessary that every physician of our school becomes a strong organization State Society individual to combat the influence of the socialistic workers who are endeavoring to advance the interest of the working man, regardless of the rights of the members of the medical profession.

New York State has been unfortunate in the amount of social legislation with which the profession has had to combat, and were it not for its medical organizations the profession would soon be overwhelmed by these influences. These measures cannot be combated from a member of medicine alone. The particular interests of the homœopathic school must be taken care of by efficient organizations. This is one of the functions of the State Society, combined with plans to institute Protective Insurance of its members against Malpractice Suits instituted against them. This will add a distinctly business feature to the organization which will be of value to every member and it is incumbent upon every member to be informed as to the exact function of this part of their organization.

From an economical standpoint the financial saving made by every member of the organization in securing this protection will nearly defray the expense of his attendance at the meeting. When added to these already stated functions is the scientific program which this year is most complete and the scope of which covers practically every department of medicine our rewards for attending the meeting are assured.

Members of the profession who remain in their own localities and do not broaden out by attendance at the various



society meetings are not only doing an injustice to themselves personally, but are also failing in their responsibility they owe to humanity to broaden the influence and carry the standards of homœopathy to places where its protective influence will add materially in reducing the disability and death rate of our country, for much as we dislike to regard the man power of the United States as one of its great resources the closest proximities of all four corners of the earth demand at this time that the highest point of efficiency be respected as the powerful force for good throughout the world.

ROY UPHAM.

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### THE DEARTH OF NURSES.

IN every State, and in every hospital, there is a demand for nurses. So serious has become the shortage that hospitals are, in some instances, closing wards or limiting their admissions. The nursing profession is one of the most honorable open to women, and it is unfortunate that more girls do not go into it. The pay is excellent, and the work interesting. During the recent influenza epidemic the demand was fully four times the supply. Even under normal conditions such as exist at the present time, there are not sufficient nurses.

We would urge upon our readers that they do their best to remedy the evil by recommending young women who have high school educations to apply for admission to one of our training schools.

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PNEUMONIA IN INFANCY AND CHILDHOOD WITHOUT PHYSICAL SIGNS.—Dr. Rowland Godfrey Freeman states that since the adoption of the routine use of the roentgen ray in hospital cases, pneumonias have been discovered when no physical signs of their existence have been found, and even after their demonstration by roentgen ray and the determination of the pneumonia, subsequent physical examination has proved entirely negative. He cites three cases coming under his observation in all of which the X-ray showed a definite shadow beneath the right axilla. In none of these patients were physical signs demonstrable

An interesting point about these cases was that they all involved approximately the same portion of the right lung, and, as the consolidation did not run up to the apex, it might be considered an involvement of the right middle lobe. If, however, it was the right middle lobe it should have been possible to obtain signs over the anterior chest and it is much more probable that the involvement was of the right upper lobe and that the signs were obscured by the right scapula. It is most remarkable that they gave no signs in the axilla.—*Archives of Pediatrics*, January, 1920.

## GLEANINGS

### MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

**THE PHYSICAL SIGNS OF FOREIGN BODIES IN THE BRONCHI.**—McCrae has been associated as medical consultant with Jackson in a phenomenally large number of cases of foreign bodies in the bronchi, and has had an experience such as befalls very few, if any, internists. His observations, therefore, are of more than ordinary interest to the general practitioner who, after all, is the first one to observe cases of this character. Contrary to common belief, foreign bodies in the bronchi are by no means mere curiosities. Many instances have been reported in which the accident has occurred without the knowledge of the victim, it being possible for no disturbance to occur at the time of entrance of such foreign body, so that in the history of the illness there is no suggestion of the accident. The X-ray of course enables us to make an exact diagnosis when the foreign body is of an opaque character. In the case of such objects as peanuts, particles of food, and these are unquestionably the most dangerous, the X-ray is valueless. Such foreign bodies also set up a very active general process which is fairly distinctive. Bodies such as metallic objects cause permanent changes, usually in the lower lobe. The chief errors in diagnosis are to mistake the signs for those of pneumonia in the early stages and in the stages of tuberculosis, after the object has been present some time. The signs of value are especially decreased expansion on the affected side, the presence of very fine rales which the author compares to the crackling of tissue paper and the asthmatoïd wheeze. The latter is present in over 50% of the cases and has been fully described in these pages. —*American Journal of the Medical Sciences*, March, 1920.

**THE PREVENTION OF MERCURIALISM.**—The difficulty inherent in the administration of mercury has been the effects of the drug upon the mouth which at times have been very exasperating. Physicians have endeavored to prevent it by careful attention to mouth hygiene and indeed have consumed time preliminary to treatment by having the patient taken in charge by a dentist. Irving has found by experience that the administration of one teaspoonful of sublimed sulphur each night by the mouth does away with salivation and the ill effects of the drug; the only attention the mouth required being such as would be given to it by any ordinarily careful individual. Whether this method also interferes with the therapeutic action of mercury, is not stated by the writer. Evidently he considers that the drug acts as well as it does under ordinary methods. The mercury sulphide is produced and this is non-soluble and may be therapeutically inactive. Irving, however, appears to have complete confidence in his results.—*British Medical Journal*, January 31, 1920.

**A SIMPLE TREATMENT FOR RINGWORM OF THE NAILS.**—Craik advocates a lotion of 3j of salicylic acid in 3jss of methylated spirit, to be painted on after scraping every night, and without scraping every morning, and to be used for three months or longer.—*British Medical Journal*, February 7, 1920.

CEREBRO-SPINAL FEVER IN INFANTS AND YOUNG CHILDREN.—Dr. Helen Mackay has treated a series of eight cases in young subjects without a death. She lays great stress upon her technique which may be considered under two heads. First, she continues the daily spinal administration of polyvalent antimeningococcal serum until all evidences of the meningococci have disappeared from the spinal fluid. Secondly, she insists upon repetitions of lumbar punctures from day to day or time to time until all increased spinal tension has disappeared. She lays special stress upon the latter as being important in the chronic case.—*The Lancet*, January 31, 1920.

PSEUDO-FLATULENCE OR "WIND GULPING."—In discussing this subject, Small comments on the frequency of hysterical features. One week the patient may be in comparative health, the next her gastric symptoms are very pronounced. Various stigmata of hysteria may be present, but these are by no means invariable. There is generally, however, an exaggeration of the knee-jerks, showing increased excitability of the central nervous system. The mental excitement which may accompany the attacks of eructation may be so extreme as to amount occasionally to a sort of delirium.

Gastric pseudo-flatulence is most commonly the result of "wind gulping," though the air may be ingested in other ways. The condition is similar to a pathological habit of the same nature, which is well known amongst cattle.

Treatment must be commenced by explaining to the patient the origin of her flatulence, and warning her that the habit of wind gulping must be discontinued. A diet should then be prescribed similar to that used in flatulence of natural origin; it should exclude substances liable to fermentation, especially carbohydrates, and is therefore to consist, as far as possible, of proteins. Milk, finely chopped meat, fish chicken, rabbit, jellies, curds, and a little stewed fruit should form the major part of it. The meals should not be too large, and must be taken at regular intervals, and well masticated. Of drugs, nux vomica is the most useful, and may with advantage be combined with some antispasmodic, such as tincture of capsicum, spirit of chloroform, spirit of aromatic ammonia, made up with a bitter infusion. The mixture should be given before food.—*Therapeutic Gazette*, Feb. 15, 1920.

PULMONARY SYPHILIS.—In a paper from the Department of Medicine of the Jefferson Medical College, Funk expressed his belief that late syphilis of the lung occurs clinically more often than is generally taught. Diagnosis is difficult and judgment may have to be suspended until lues has been controlled by treatment, when "apical rales" will clear with the associated bronchitis if signs are due to syphilis. The author reports in detail three cases of what he believes were pulmonary syphilis that have come under his own observation. In arriving at a diagnosis the following points are important: (1) the history; (2) signs of syphilis in other organs; (3) the location of the lesion—syphilis usually involves the hilum areas of the bases, unusually rare locations for primary tuberculosis lesions; (4) the persistent absence of tubercle bacilli when signs of advance pulmonary disease are evident; (5) a positive Wassermann reaction when all tests for tuberculosis are negative; (6) certain roentgenographic features which the author gives in detail; and (7) the response to anti-syphilitic treatment.—*Amer. Rev. Tuberculosis* Vol. 111, No. 12.



## GYNECOLOGY AND OBSTETRICS

Conducted by Norman S. Betts, M.D.

ROENTGEN THERAPY IN GYNECOLOGY.—(W. H. Meyer, *New York Medical Journal*, Jan. 24, 1920). A summary of the salient features of this article is presented as follows: The possibility of cure of superficial malignancy by radiant energy is practically conceded in every quarter. In the treatment of deep growths complete resolution is to be expected only if a lesion is so situated that the dose known to be destructive to the particular type of cell can by multiple area cross fire be brought to bear. A somewhat smaller dose may bring about an inhibitory action on the growth, but with smaller doses the danger of stimulation rapidly increases.

In as few words as I can muster, this is the status of the treatment of malignancy by radiant energy as it appears today; my only comment here is: Know that your radiologist knows his roentgen ray and prohibit the promiscuous use of this agent by unskilled and untrained incompetents. On the other hand, strict co-operation should exist between the surgeon and radiologist for both preoperative and postoperative radiation, that more may be made of the X-ray department than the dumping ground for operative failure and moribund cases. This leaves us still with some gynecological conditions amenable to roentgen therapy; perhaps a little less serious, but still of extreme importance and with greater certainty as to result. I have reference to uterine hemorrhage, menorrhagia, metrorrhagia, symptoms of the menopause and uterine fibroids. As far as these conditions are concerned, I can say that in a single treatment of from forty to ninety minutes' duration, depending upon the size of the patient, a permanent cessation of the menstrual function and hemorrhage can be produced.

The fibroid growths best suited to irradiation are the intramural type. The subperitoneal and particularly the pedunculated type, had best be removed surgically. The submucous or polypoid type of fibroids are practically contraindications to the use of radiotherapy. When complications and above all malignancy do not exist, the results are uniformly good. A careful examination and correct diagnosis are essential or the result may be anything but pleasant.

OVARIAN RESIDUE.—Graves (*Surg., Gyn. and Obs.*, December, 1919) gives the results of his experience in the treatment of the natural and artificial menopause, amenorrhoea, delayed and scanty menses and dysmenorrhoea by the use of ovarian residue. This term he defines as that part of the ovary which remains after ablation of the corpus luteum. He summarizes his impressions as follows: 1. That the ovarian secretion is not solely confined to the corpus luteum. 2. That the secretion of the atretic follicles and the corpus luteum is a similar product being manufactured by analogous cells, namely by those proliferated from the internal theca. 3. That the ovarian residue preserves its chemical integrity longer than do those ovarian preparations which contain corpus luteum substance. 4. That under present conditions of preparation ovarian residue is in general superior in its clinical results to the commercial articles now on the market.

## DERMATOLOGY

Conducted by Ralph Bernstein, M.D., F.A.C.P.

**ERUPTION FROM CONTACT WITH SPOILED GRAIN.**—Since 1915 several epidemics have been reported by Romiti of a papulous dermatosis, eruptive in character, accompanied with intense itching and high fever lasting over a period of six to twelve hours. The epidemics were confined to those persons who had handled grain subject to a special pathologic process, requiring the so-called scalding, or who had handled flour made from such grain, or whose clothing had come in contact with it. In some cases the eruption would make its appearance and then disappear, only to return several times in succession, at intervals of three, five or seven days. Treatment was confined to a removal of the cause plus hot baths and symptomatic measures.—*Journ. Amer. Med. Assoc'n.*

**INFESTATION WITH LICE AS A SYMPTOM OF DISEASE.**—Jeanselme reports having time and again noticed that perfectly healthy persons may escape phthiriasis even though they may sleep with lice-infested individuals. The colonization of the lice, by preference is confined to the bodies of diseased persons, and Jeanselme remarks upon the importance of a search for serious, possibly latent disease.—*Journ. Amer. Med. Assoc'n.*

**AN ESOPHYLACTIC (PROTECTIVE) FUNCTION OF THE SKIN.**—Bruno Bloch's conclusions regarding "Dermatology in Relation to Problems of Metabolism and Immunity" are concurred in by Hoffman, who believes that the skin has an important biologic function which has not been fully recognized, by virtue of which function the vital organs are in a measure protected against disease germs. This, according to Hoffman, is one of the principal points of contact between dermatology and general medicine. The results of the recent investigations on the allergic reaction of the skin in trichophytosis, tuberculosis and syphilis led Bloch to a consideration of this question, and he lays particular emphasis upon the part that the skin plays in the phenomena of allergic immunity and of hypersusceptibility, whereas in tetanus, diphtheria, etc., the blood is the carrier of the prophylactic forces. This assumption is sustained by the fact that when the skin is extensively affected in tertiary syphilis and lupus, the internal organs so frequently escape, as well as the part played by the skin in overcoming exanthematous infectious diseases. Hoffman is of the opinion that the skin produces immunizing materials that exert a healing influence for, in view of the slight penetrability of the short wave rays used in phototherapy, he can find no other explanation. Owing to the importance of such a function of the skin in connection with biology and general pathology, Hoffman has reported in detail the various angles from which he has viewed this assumption, believing that the hypothesis might cause others to research.—*Journ. Amer. Med. Assoc'n.*

**PAGET'S DISEASE OF NIPPLE.**—Handley reports that the probabilities all favor the view that the lymphatic obstruction which is the cause of Paget's eczema is the result of neoplastic and not mere inflammatory obstruction of the lymphatics. Even if in rare cases it is possible that the eczema results from a block in the lymphatics of inflammatory origin, it is certain that this form of chronic inflammation of the ducts is a very dangerous condition

which almost invariably leads to carcinoma. Paget acknowledged that in all cases in which he excised the eczematous nipple a carcinoma subsequently appeared in the breast. Early and complete removal of the breast is, therefore, demanded whatever the view adopted as to the order in time of the eczema and carcinoma.—*Journ. Amer. Med. Assoc'n.*

**DIATHERMY IN MOUTH CANCER.**—Patterson regards diathermy as the best method to adopt in the treatment of all cases of epithelioma of the mouth. No incision of a carcinomatous growth in the tongue, mouth or pharynx, no matter how small it may be, should be carried out with the knife if diathermy is available. Patterson, encouraged by the good results which he obtained in cases where the disease was limited, has applied the method in advanced cases where nothing could be really expected from treatment of any kind. Patterson believes that if patients could only be seen soon enough a large number of cures would probably be effected.—*Journ. Amer. Med. Assoc'n.*

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### OPHTHALMOLOGY

Conducted by WM. M. HILLEGAS, M.D.

**UVEITIS—ETIOLOGY AND PATHOGENESIS.**—De Schweinitz in his clinical lecture and Jackson in his address, give splendid synopses on the etiology of uveitis; with special reference to focal infections, with illustrative cases. Both emphasize the notable advance of our knowledge within the last four years, which throws an entirely new light on this subject. Rheumatic iritis has disappeared from our classification of iritis and chronic rheumatism has given way to focal infection. The patient gets an inflammation of the uveal tract, not because he has rheumatism in the strict sense of the term, but because his uveitis is a manifestation of toxemia coming from the infection of which he is the subject; and his muscle, joint, and fibrous pains and lesions are other manifestations of the same cause. It is probable that almost every case of inflammation of the uveal tract is of septic origin, which may be exogenous or endogenous. Sometimes the uveal tract is involved in an inflammation which in all probability is non-bacterial in origin; and de Schweinitz considers it reasonable to believe that iridocyclitis, which is frequently present in the subject of gout, is caused by, or at least associated with, the defective nitrogen metabolism which underlies gout; and that there is a similar connection between iridocyclitis and diabetes.—*International Clinics*, 27th Series, Vol. 3.

**INFLUENZA.**—The world-wide epidemic of influenza gave rise to an extensive literature, but comparatively little of this refers to the ocular symptoms and complications. Menacho at Barcelona observed 13 cases. These included acute glaucoma becoming absolute in one case, hemorrhagic neuroretinitis with extension of the hemorrhage into the vitreous, partial paralysis of the third nerve, neuritis of the ophthalmic branch of the fifth nerve, keratitis, conjunctivitis, dacryocystitis, and accommodative asthenopia. In all these cases the attack of influenza seems to be an essential factor in the causation.—(*Arch. de Oft. Hisp. Amer.*, V. 19.)

Stieren reports that of 325 cases 54 were referred to the eye department. The usual lesion was acute congestion of the conjunctiva, which was relieved by cold moist compresses. One patient developed a uniform haze of the



cerneal epithelium, which cleared up under atropin and dusting with calomel. Two cases of double orbital cellulitis recovered without abscess.—*Amer. Journ. Ophth.*, Vol. 2.

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## SURGERY

Conducted by J. D. ELLIOTT, M.D.

EMPYEMA AT THE CINCINNATI GENERAL HOSPITAL DURING THE INFLUENZA EPIDEMIC.—Ransohoff reviews the results obtained in forty-six cases of empyema which came to operation during the pandemic of influenza in 1918-19 and in concluding his paper makes the following summary: 1. Empyema complicating influenza is in itself not responsible for death; too early operative measures should be avoided and should be limited to simple aspiration. 2. Operation not earlier than the end of the second week gives the best results. Rib resection is indicated only when sufficient space is not at command without it. 3. General anesthesia is not necessary in most cases, but in our experience does not increase the mortality rate. 4. The old methods of drainage should be given up for some type of the occlusion method, by which the entrance of air to the pleural cavity is prevented and the exist of pus facilitated. A suction apparatus attached to the tube is deemed unnecessary. 5. Flushing of the cavity with Dakin or other solution is unnecessary, except when defervescence does not occur, which indicates that spontaneous sterilization is not progressing normally. 6. The small pneumothorax which sometimes remains after the healing of a cavity, as has been demonstrated by the Roentgen ray, is negligible, since it disappears spontaneously in a short time.—*Jour. of the A. M. A.*, Jan. 24, 1920.

UNUNITED FRACTURES OF THE HIP.—Henderson is not very enthusiastic over the results obtained in the treatment of ununited fractures of the hip and, after having reviewed 120 cases of such fractures of the neck of the femur, draws the following conclusions: 1. The most common cause of non-union is that the fracture is not recognized at the time of the accident. The disastrous result, therefore, is the result of no treatment. In cases in which the diagnosis is correctly made the treatment is often faulty and weak. An impacted fracture must be kept impacted until united. 2. As a group at large, ununited fractures of the hip offer a comparatively small percentage suitable for surgery; 26 (2.6 per cent.) of the 120 patients were operated upon. In 10 of the cases operated (38 per cent.) the operations were successful, giving, however, for the entire group of 120 cases only 8.3 per cent. successfully treated. 3. Advanced age, poor general health, etc., are contraindications to operation, but the chief contra-indication is absorption of the femoral neck. A person of 25 years may, in 5 months after the accident, show so much absorption of the neck of the femur that none of the measures considered offer any hope. 4. Any means, in suitable cases, that will freshen the fractured surfaces and maintain them in apposition is sufficient, but autogenous bone pegs are the most ideal. 5. From our experience, the fibula seems to be the best piece of bone to be used; it is easily obtained and is never missed by the patient if it is removed anywhere four inches above the external malleolus.—*Surgery, Gynecology and Obstetrics*, February, 1920.

**A REVOLUTION IN TREATMENT OF CONGENITAL DISLOCATION OF HIP IN YOUNG CHILDREN.**—A review of the literature of the anatomy of congenital dislocation of the hip shows that the head and acetabulum are normal and the muscles not contracted until weight has been borne upon the affected limb. It is only after the child has walked that the muscles become contracted, the upper dislocation results in a stretching of the ligamentum teres and ultimately the artery accompanying the ligamentum teres fails to functionate, which results in a malformation of the head of the femur.

Frauenthal, in 1918, replaced a congenitally dislocated hip in a two year old boy without an anesthetic and was surprised to find that the hip could not be displaced and that the head of the femur remained firmly fixed in the acetabulum. During the following year he repeated this procedure in 25 cases and in only 2 of them has it been necessary to apply a cast for fixation. The pelvis is held fixed by an assistant; the thigh is completely flexed upon the abdomen; pressure is made upon the knee which brings the head of the femur under the acetabulum and, as the leg is rotated outward in the flexed position, the head of the femur is raised into the acetabulum with the fingers of the other hand. The whole procedure in these cases is accomplished in less than a minute's time. The child is immediately placed on the ground and allowed to walk; in one case a child, aged 2 years, walked seven blocks on leaving the dispensary immediately after the operation.

This method is not adapted to children who have walked upon the affected limb for six months or more; then the old Lorenz method must be resorted to. It is effectual only when the child first starts to walk and the oldest patient in whom it has been effectually accomplished was  $2\frac{1}{2}$  years of age. The great saving of time and mental suffering should make this the method of choice, to be followed by the plaster-of-Paris fixation if a failure of retention develops.—*Jour. of the A. M. A.*, Jan. 10, 1920.

**TREATMENT OF GOITER WITH INJECTIONS OF PHENOL, TINCTURE OF IODINE AND GLYCERIN.**—During the last two years, Sheehan and Newcomb have injected 80 cases of all forms of goiter with a mixture of equal parts of phenol (carbolic acid), tincture of iodine and glycerin. They also injected a limited number of cases with boiling water, but with poor results and are doubtful as to its efficacy. The authors state that they have cured 42 out of 55 patients with parenchymatous goiter; have improved 12 out of 14 cases with exophthalmic goiter, but have done no good in 11 cases of cystic, colloid and adenomatous goiters. The relief in the exophthalmic cases is only temporary, but is of much aid in pre-operative preparation and of some good in inoperable and otherwise hopeless cases. Actual damage may result from sudden enlargement of the thyroid after injection in the cystic or colloid forms.

Five drops of equal parts of tincture of iodine, chemically pure phenol and glycerin are injected into the most prominent part of the gland. The needle is plunged directly into the substance of the gland, and the patient is told to swallow. If the needle is in the gland it will have a wide upward and downward movement during the act. If the needle is extraglandular no such excursion will take place. Care should be taken to inject the material very slowly, as hasty injections cause great pain which may be referred to the ears. Other times it will be referred to the jaw and sides of the neck. There is always some pain which takes place after the fluid has been injected, but this subsides within a short time. If too much material is injected, alarming symptoms of acute strumitis may set in. Some patients feel weak; others

may actually faint. The interval of treatment is generally five days, but the frequency of the injections will be in direct ratio to the reaction. Some may accept treatment every three or four days, others between the fifth and seventh days. It is never safe to inject more than 12 drops. After the fifth injection one can readily determine the progress of the case. In some cases five injections suffice; in others many more may be needed. In one case of the series of fifty-five, as many as twenty-six injections were given before a cure was effected.—*Jour. of the A. M. A.*, Jan. 19, 1920.

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## PEDIATRICS

Conducted by C. S. RAUE, M.D.

THE CLINICAL ROLE OF THE FAT-SOLUBLE VITAMIN: ITS RELATION TO RICKETS.—Alfred F. Hess and Lester J. Unger, 18 months ago, undertook the study of rickets in about 100 infants cared for in a modern children's institution. The infants lived under excellent hygienic conditions, their nursing and care was the same, their food was prepared in a central diet kitchen, and they remained in the institution for the entire period of observation. They were placed on various diets—an abundance of fat and fat-soluble vitamin in the form of milk and cream; a deficiency of these substances, as in skimmed milk; an abundance of water-soluble vitamin as supplied by autolyzed yeast; or diets such as Mellin's Food or condensed milk. In all cases there was but one deficiency in the diet, which was adequate in quantity, in its caloric content, and contained in every instance sufficient antiscorbutic foodstuff. The authors stress the fact that in a study of rickets, whether in infants or in animals, it is essential to have the diet complete, except for the one factor under investigation, and especially that it should contain adequate amounts of the antiscorbutic and of the water-soluble vitamin.

At the outset of the investigation, attention was directed to the influence of hygienic and non-dietetic measures on the development of rickets. It was found that rickets can develop notwithstanding an abundance of fresh air. It was found likewise that a liberal amount of light could not prevent the development of this disorder. As regards the fat-soluble vitamin, a number of infants, during the first months of their lives, were placed upon a diet containing an adequate amount of this important dietetic factor in the form of large amounts of milk to which, in some instances, cream was added. By this means, if fat-soluble vitamin is the controlling influence, the development of rickets should have been prevented. In some cases, with this dietary, which included orange juice, a very mild degree of rickets was observed, but in others marked signs developed. It was noted also that rickets appeared in several instances on 24 ounces daily of protein milk (containing about 2.5 per cent. of fat) and even in nursing infants whose mothers were on a diet that included a large quota of milk, butter and vegetables.

Another group of infants was put on a dietary that was complete in every respect except for a lack of the fat-soluble vitamin. These babies were from 4 to 9 months of age, and somewhat below the average in physical development. After having been on this diet for periods varying from 5 to 9 months, they show no greater signs of rickets than the average baby in the institution and the only abnormal condition observed was a mild retardation in gain in weight. The authors reach the following conclusions:

"It would lead too far afield to discuss the various theories that have been advanced to account for the occurrence of rickets, and, moreover, it



would not be profitable at the present time, as the data are inadequate. There seem to be several causes at work, rendering the unraveling of the problem so difficult that there is a difference of opinion not only as to the particular dietary factor that is at fault, but even as to whether rickets is to be considered a disorder of dietetic origin. It should not be lost sight of that there is a prenatal factor involved. The fact that the negro infant, living side by side with the white in the larger cities and obtaining milk from the same source, develops rickets so frequently and so markedly, indicates that there are important influences to be reckoned with in addition to the food.

"In considering the diet a most important question is whether the recent theory as to the vitamin origin of the disorder can be maintained and, more particularly, whether rickets should be attributed to a lack of the fat-soluble factor. We can obtain the clearest understanding of this aspect by comparing this disease to the well-recognized and established deficiency diseases, scurvy and beriberi. What does the comparison show? In the first place, these two disorders are commonly accompanied by weakness and malnutrition; we do not encounter the strong, apparently healthy babies met in rickets. But of far greater moment is the fact that neither can be brought about by over-feeding. Rickets frequently develops in infants receiving too much milk rich in fat, protein and salts. It seems impossible to bring this fact into consonance with a deficiency disease, whatever may be its nature, using this term in the commonly accepted sense. Our study shows that the fat-soluble vitamin is not the controlling influence; that infants develop rickets while receiving a full amount of this principle, and that they do not manifest signs, although deprived of this vitamin for many months, at the most vulnerable period of their life. It is impossible to interpret the contrary conclusion which Mellanby came to as the result of his pioneer experiments on dogs, or to accept the term fat-soluble vitamin as synonymous with antirachitic factor, as Hopkins and Chick would have us do. Clinical tests carried out with care must be accorded fully as much weight as laboratory investigations. The two methods of approach should be carried out side by side, and even the most thorough study on animals must be made to harmonize before it can be accepted as holding good for man.

"Finally, this work seems to show that the danger to infants of a diet deficient in fat-soluble vitamin is slight, provided it includes sufficient calories, and otherwise is complete. They can maintain their health and vigor despite amounts of fat-soluble vitamin so small as rarely to be encountered in times of peace. In spite of the fact, therefore, that this vitamin is not widely distributed in nature, a disorder that may be termed fat-soluble deficiency—marasmus or xerophthalmia—is hardly to be apprehended from a clinical standpoint."—*Journal of the Amer. Med. Asso.*, Jan. 24, 1920.

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## UROLOGY

Conducted by LEON T. ASHCRAFT, M.D.

THE ROLE OF THE X-RAY IN THE DIAGNOSIS OF LONG-STANDING RENAL TUBERCULOSIS.—Colston and Waters (*Bull. Johns Hopkins Hosp.*, 1919, xxx, 268) as the result of their experience, have reached the conclusion that x-ray studies of the entire urinary tract should be carried out in all cases of suspected renal tuberculosis. When other methods of examination have failed, it is possible in some instances to reach a definite diagnosis of tuberculosis of the kidney by means of the plain x-ray alone. Whenever

possible, however, the other ureter should be catheterized, in order to establish the integrity of the opposite kidney. The shadows seen in the plate depend upon the amount of calcification that has occurred in the diseased kidney. These shadows vary from the indefinite ones cast by small areas of calcification to the characteristic lobulated shadow caused by the completely destroyed kidney. Pyelography and cystography should not be resorted to, unless the diagnosis cannot be cleared up by simpler methods.

THE DIAGNOSIS (?) OF RENAL COLIC.—Stark (*N. Y. State Jour. Med.*, 1919, xix, 331) believes that renal obstruction is a condition that has been much neglected by the profession. Renal colic is caused by obstruction in the urinary tract, the commonest etiological factors being strictures, kinks, accidental tying off of the ureter, stone in the ureter, adhesions and the pressure of tumors. The pathological conditions usually confused with renal colic are appendicitis, duodenal ulcer, peritoneal adhesions, pancreatic disease, lumbago and neurasthenia. Any patient with abdominal pain and pus in the urine, if there is frequency of voiding or a history suggestive of renal colic, should be referred to the urologist. When difficulty is found in passing a number six or seven ureteral catheter, a smaller one may be used and reinforced with a wire, thus enabling the operator to pass the obstruction, relieving the patient of pain and gastric symptoms and producing a fall in temperature. In the treatment of the condition, the author passes ureteral bougies varying in size from filiform to number twelve F.m. operating them through the water cystoscope. His treatment is based on drainage and irrigation.

DILATATION OF THE URETER AND THE RENAL PELVIS.—Braasch (*Jour. Am. Med. Ass'n.*, 1919, lxxiii, 731) lays particular emphasis on the dilatation resulting from inflammation. He ascribes dilatation of the ureters and renal pelvis to three causes, viz.: mechanical obstruction, infection and disturbances of innervation. Although these are frequently found in combination, each may be demonstrated as a distinct clinical entity, clinically, pathologically and pyelographically. When the dilatation is due to the first of these etiological factors, it is observed in the renal pelvis rather than in the calices or ureter. Intermittent mechanical obstruction is nearly always accompanied by pain caused by overdistention of the pelvis and ureter. Inflammatory dilatation produces more thickening in the walls of the pelvis and ureter than does mechanical obstruction, and the ureters are often tortuous. Microscopic examination shows evidences of inflammatory changes resulting from infection. It differs from the dilatation produced by mechanical obstruction in that it is greatest in the calices and ureters rather than in the pelvis. Inflammatory dilatation often accompanies renal calculus. That mechanical obstruction is not a factor is shown by the fact that stone, is often securely lodged at the end of the calyx. Clinically, there is usually no pain referred to the kidney, but rather a history of repeated febrile attacks. Disturbances of innervation in the central nervous system, producing an atonic condition of the bladder also produce, in the author's opinion, a dilatation of the ureter and renal pelvis. While some have considered this due to the backing up of urine from an overdistended bladder, Braasch says that it often occurs when no residual urine is present, and thinks that it may be attributed to the same cause as that affecting the bladder. It may, however, occur when there is no evidence of any disturbance of the central nervous system. Moreover, both ureters may be dilated, and the kidneys hydronephrotic in the absence of evidence of mechanical obstruction.

# THE HAHNEMANNIAN MONTHLY.

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MAY, 1920

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## SAD SISTERS FOUR—AN ALLEGORY WITH A PROLOGUE.

BY

H. O. WILLIAMS, M.D., LANSDALE, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

### THE PROLOGUE.

IF now, as recorded in Gen. 6: 3, the longest possible life of a man shall be one hundred and twenty years; nevertheless, the life of a principle, founded upon truth, is eternal. If the reasonings of Hahnemann were false, we are dupes. If, on the other hand, the deductions of Hahnemann are true—and having withstood the attacks of malice, injustice and ridicule for over a century and a quarter at the hands of a combined and major force, is alone a sufficient proof or guaranty of their virtue—then the years to come will not only strengthen their foundations but will, anon, plant them even more deeply, provided we the keepers of the treasury are true.

The abilities of the Homœopath in the recent great World War, bridled though he was, were so notably prominent that had he been given a free hand to practice his art as he was taught and knew, the results would have been not a mere conjecture. Given an equal opportunity on an equal basis, as, for example, the epidemic of influenza of the past year, the practitioner of the Law of Similars needs no eulogy save the results of his labor.

However, we are not unmindful of the fact that Homœopathy, as practiced to-day by the majority of our school, would be termed a *mongrel* rather than a *pure* Homœopathy by Hahnemann; and we do not doubt but that the shades of this



great pioneer oft stand aghast in horror at the careless, faulty and unhomœopathic manner in which we, his followers, oft select the remedy to be applied to a diseased condition. Indeed, should the entire homœopathic profession during the next decade dedicate themselves to a closer study, proving, selection and application of the homœopathic remedies, we believe the result would be such an impetus to homœopathy and its cause that the medical world would gaze on in wonder.

On the other hand, we are not forgetful of the fact that the definition of a homœopathic physician as accepted by the American Institute of Homœopathy—and America is now the home of Homœopathy—gives him a very wide field of operation; yet, as pertains to pure homœopathy, how fitting is the text:

“If ye know these things, happy are ye if ye do them.”

We know that the life of the homœopathy that is to come depends upon us, and we can select no more fitting words pertaining to it than those of Whittier, who, speaking of our own individual futures, says—

“The tissue of the life to be

We weave with colors all our own,

And in the fields of destiny

We reap as we have sown.”

And so, O men, it is we who are helping to shape the destiny of homœopathy. Are we remaining true to our trust? Have we not, in a sense at least, been drifting? It takes more sturdy arms to pull against the current than to drift with the tide. It is easier to prescribe a “laryngitis tablet” than to ferret out the totality of the symptoms. It is easier to prescribe for “one symptom or a few” rather than to obtain and study them all. We feel pretty sure that our successes or our “cures” show a direct proportion to the “amount of ease” we have taken in making our prescriptions. The totality of symptoms oft might lead us to select an entirely different remedy than was suggested by the few. For example, we may have given us a number of symptoms suggestive of *puls.* We may have forgotten to elicit the fact that the patient wishes to be kept warm; a cool or chilly air or atmosphere makes her worse. If we have prescribed *puls.* to this patient our prescription will have been in vain if we expect a cure.

In selecting our subject for this occasion we probably would have appeared more scientific had we elected, or been

able, to discuss some new remedy or to bring forward some entirely new phase of one already familiar. For example, too a treatise on "Food Alligens" or "Food Idiosyncrasies," being a rather recent line of investigation by some men of science, would have sounded well, no doubt, but have we not as homœopaths learned long long ago that the *ferrum* patient cannot eat eggs nor the *colchicum* patient even stand their odor; that the *lycopodium* patient nearly dies if he eats an oyster and the *sabadilla* patient cannot tolerate an onion; and now since July first, A.D. 1919, it is altogether quite likely that *nux vomica* will lose prestige on the list of so-called "banquet remedies," these and other symptoms such as these have been land-marks to the homœopath for the past hundred years and more.

We have, accordingly, decided upon an old subject, just reclothing it. We have done so with reason. We have done so hoping to here re-awaken a closer study of symptomatology. We will try therefore to discuss by a comparative analogy the chief guiding symptoms of a family of remedies that have been much neglected by many of us, using the form of an allegory to express ourselves the more forcibly and, we trust, the more clearly. We refer to the *natrum* family and it is because of lack of provings that we have purposely omitted *natrum phos.* from this analogy.

#### THE ALLEGORY.

The *Natrum* family ought to have been an exceedingly happy one. The advent of "quadruplets" into any family is an unusual occurrence and when it does so happen it is assumed that the family visited is highly favored. Beyond doubt the parents are shocked at the first evidence of the magnanimity of the blessing heaped upon them all so suddenly, yet they shortly regain their composure and exhibit their multiple progeny with much satisfaction and not a little pride.

The *Natrum* family was blessed, as just mentioned, and this quartette of young ladies, so assumed, were named respectively *Natrum ars.*, *Natrum carb.*, *Natrum mur.* and *Natrum sulph.*

Contrary to the hopes and expectations of the fond parents their progeny did not thrive. Instead of developing into robust and lusty little ladies, they early exhibited signs of

*anaemia* and *emaciation*. As time went by without any improvement but with signs of continued *malnutrition* it was decided to call in the family physician.

Dr. Gruff was summoned. After a close and studied examination he addressed the parents as follows—"Your babies are slowly starving and this beyond doubt from inherent causes. I find here undisputed evidence of *sycosis*; indeed, this is so self-evident in the case of *Natrum sulph.* that I would assume that her sisters are naturally in the same manner impregnated with the same poison. However, the symptoms of the others are not so clear and I would advise that——." Here he was rudely interrupted by Mrs. Natrum turning to her husband and saying—"I have always suspected, Mr. Natrum, that in your younger days you were not the saint you have since posed to have been. 'Truth crushed to earth shall rise again' every time and here it is. You ought to be ashamed to have ——." "Hold your tongue, woman," blurted in Mr. Natrum, "If you are as free from all transgressions as you are free to accuse, you stand as a monument of purity. Never have I posed as a sinnerless saint and then to be hauled up and shot at in this open manner I will never stand. I warn you ——." Here taking a step forward evidently to emphasize what he was about to say, he accidentally overturned the chair upon which *Natrum mur.* was lying and sent her unceremoniously upon the floor. Dr. Gruff, realizing that the melee was the result of his rather unguarded remarks, picked up the screaming infant and tried to console her, but *she would not be comforted*. Finally, in despair, depositing the baby upon a near-by couch, he hastily left the house.

The result of that family jar has never been revealed. Time passes. The babies all lived and grew, and as young ladies we find them assembled upon the lawn of their parental home one beautiful day in June. As young ladies we would expect to find them a merry group of laughing maidens, while, in truth, a more *dull, moody, irritable, pensive* set of offspring, with an *occasional burst of wit, laughter or gaiety*, never invaded the sanctity of any home.

*Natrum ars.* was very *restless* and *exceedingly nervous*. She *could not sit still*. She plucked a tiny flower, frowned at it and threw it away. She gazed vacantly and vaguely into space. She was *mentally dull*. Her fond parents verily insisted that her vocation should be that of a teacher, but alas,



because of mental dullness and inability to concentrate her thoughts, the attempt had been abandoned. Indeed, *mentally dull, tearful* and *sad* characterize these four sisters, as much alike as four peas in a pod.

*Natrum ars.* began by saying, "Dear me, I have such an awful headache. I have it every morning on arising. It is such a *throbbing pain in my forehead* and it *feels so full*. It is peculiar in that it is *always in the morning* and always in my forehead. My eyelids are then glued together. I have granulated lids."

"Speaking of headaches," replied *Natrum carb.*, "my allotted portion is very sufficient. I, too, have that *pressing frontal headache*, but it is generally present *in the evening*. But, oh, my, that sun, *I cannot stand that sun*. I must get into the shade. For every walk in the sun or exposure to the sun, my reward is a splitting headache. And do you hear that *music*? That certainly *unnerves me*. I wish those people over there would sell that piano. Every time I hear it I've got to weep and it makes me feel like thirty cents."

"Well," rejoined *Natrum mur.*, "everything has an inflated value these days. You're a fool, *Natrum carb.* You surely are a fool. Why don't you 'can' some of your feelings and go out into society? Every time the sun peeps at you, you imagine you get a headache; and every time a man peeps at you, you wither him with such a look of disgust that he hasn't the heart to try to approach. Old maid's row for you forever at this rate."

"Thanks for your unsought advice, *Natrum mur.*," replied *Natrum carb.* "It is self-evident, however, that your own brilliancy would never accuse you as being the author of 'The League of Nations.' I admit I do *hate the sight of a man*; but as to emotion caused by music, well, our entire family is moved thereby; therefore, beyond doubt—

'Fool art thou as well as I.'

"Well," responded *Natrum mur.*, "I admit that I cannot stand music, but I have a reason. I believe my headaches are responsible. They are so tremendous; they are so bursting that it seems as though a *thousand hammers* were *hammering, hammering, hammering* away to see which could strike the hardest. These attacks oft *begin in the morning, by noon their severity drives me nearly frantic*, and my *relief comes only*

with the setting sun. *Kalmia*, *Phosphorus* and *Spigelia* tell me that they suffer very similarly."

*Natrum sulph.* here interposed, "There are times when I can scarcely refrain from ending my sad existence. I am so utterly depressed and gloomy. Music surely does aggravate me, especially when so cast down. I am afflicted, too, with that fierce bursting frontal headache, but at the same time I have a severe burning on the top of my head. My only relief seems to be the pressure of my hands, so. I believe my brain is shrinking; it seems so loose. Whenever I stoop it seems to fall forward into my left temple. *Sulph. ac.* tells me that his brain seems loose too, that it seems to roll from side to side. However, the real bane of my existence is damp, wet weather. My troubles are surely multiplied then. When I was a child I had a fall, striking the pavement forcibly. I landed on my occiput and was unconscious for some time. I was informed that this was the real cause of all my troubles. This may be true but dampness, I do believe, is my worst enemy. *Natrum mur.* and I will never spend another vacation at the shore. We had no peace while there. Every trouble we had was greatly aggravated there. As a child I recall distinctly that every damp, wet day was a signal for an asthmatic attack. And then after getting drenched in that rain-storm, I can almost feel those murderous cutting pains in my side now, from the pneumonia that developed. I could not lie in my bed. I simply had to sit and hold my sides when I coughed, fearing lest they would burst. Oh, yes, I seem to be very much favored. I get everything that comes down the pike. I remember only too distinctly those severe gnawing pains at the base of my brain, when I had spinal-meningitis. That gnawing extended way down my spinal column. Gnawing is, indeed, the proper term. I was told I was receptive to disease because I was sycotic. I don't know what that is but mother says dad does."

Dinner was announced. On attempting to arise *Natrum carb.* fell back exclaiming that her ankle was dislocated. "Some one please pull it hard," she cried. "There that feels better. That ankle is weak and gives me very much trouble. I have sprained it often and just as often it has been dislocated." Continuing she added, "I'm surely glad to go in; do you see that storm approaching? I'm as much afraid of thunder-showers as is *Phos.*"

After seating themselves at the dinner table, *Natrum carb.*

began fanning herself violently. "That ankle and thunder-storm seems to have had an overheating effect upon me," she said. "I surely am warm, but I do wish some one would remove that glass of ice-water. I am tempted to drink it and if I do I know there will be a penalty to pay. *I can never drink anything cold when I am overheated.* Since I had that sun-stroke I seem to be a peculiar individual. I seem to live in two hemispheres, my head in one, my body in the other. In other words, *in summer my body and extremities are comfortable while my head cannot tolerate the heat; in winter the cold is soothing to my head but my body suffers, and my hands, feet and extremities to my elbows and knees are cold as ice.* I thank you for having removed that ice-water, now will you please do the same with this glass of milk? *Milk, especially cold milk, is synonymous with Pluto water to me.*"

*Natrum mur.* replied, "Just pass that milk to me. I'll give it a good home. That is, I will after I add a little salt. *Salt to me is essential.* 'Give me liberty or give me death', said Patrick Henry; but I say, 'Give me salt or it will be my death.' *Oysters, fish, milk with plenty of salt sounds to me most pleasing but keep away coffee and bread. I have a chronically inflamed throat and bread seems to lodge somewhere within just like a plug. Sometimes there is a sensation as of a splinter.* I once consulted our family physician concerning a set of four symptoms, viz.—(1) *a sensation of a cold wind blowing through my head;* (2) *a sensation of a hair on my tongue;* (3) *a crack in the middle of my lower lip that would not heal;* (4) *a mapped tongue with burning at its tip and ring-worm-like eruptions along its sides.* He replied, 'As to the cold wind in the head, remember that two things cannot occupy the same place at the same time'—implying that I had no brains. 'As to the hair, it is due to irritation of some terminal nerve filament—no hair would ever get a chance to grow there. And as to the lip and tongue symptoms, remember that perpetual motion will likely cause soreness and, at the same time, prevent healing.' He was very insulting and he was wrong. I get angry quickly and am spiteful, but I am *not* a great talker. I know he confused me with *Lachesis* or *Hyoscyamus*. They are wonderfully loquacious. Whenever I do speak, however, it is the truth. Now there is *Opium* and *Veratrum alb.* who eventually will have this epitaph—

'Here lie the greatest liars that ever lived'."

"Well," said *Natrum sulph.*, "I believe the doctor diagnos-



ed your condition pretty nearly correct, especially as to the brains. But let that be as it will, just let *Natrum mur.* have *Natrum carb.*'s milk, but let me have her ice-water. I believe I could drink a gallon right now, as cold as ice can make it. This is my slogan—

‘Lack of appetite but thirst for cold drinks.’

*My throbbing toothache and my hot burning gums are entirely relieved by cold water in my mouth. Even cold air relieves me somewhat. Hot drinks are simply intolerable. I have a sore throat very much like Natrum mur.'s. I cannot swallow solids, they just draw my throat up like a purse-string. Even talking aggravates.*”

“If that’s the case,” said *Natrum mur.*, “it evidently isn’t very sore now.” Continuing she added, “I wish I had a better stomach. *Acids never did agree with me.* I should have refrained from eating those tomatoes; they always give me pain and heart-burn. I might have known they would for I have been having nausea every morning for the past week.”

“Well,” retorted *Natrum sulph.*, “morning sickness is always a very suspicious symptom. I trust your case is not one of sour-grapes instead of tomatoes.”

For an answer *Natrum mur.* emptied the contents of a cream pitcher into *Natrum sulph.*'s face, saying, “I trust you enjoy cream more than I enjoy slander. My menses are late just at present, but I would have you know that I am a lady. *My periods are oft-times late and scanty but just as likely and as often they are early and profuse.* What is most peculiar is that *my mouth is so very dry at those times.* Another peculiar occurrence is much itching locally around the pubes and a falling off of the hairy growth.”

“As for me,” said *Natrum sulph.*, “*my blood is so acrid* that I seem to be parboiled. It makes me so extremely sore that I can scarcely walk at times. *I am covered, locally, with small vesicles and pustules, too.* More sycosis I was informed. As to time I am always late and always scanty.”

“On my part,” said *Natrum carb.*, “I am too early and it lasts too long. My worst trouble is, however, that *I seem to be losing all my pelvic organs.* *Sepia* and *Lilium tig.* complain of the same symptoms, as you know. But *Sepia* is relieved by crossing her legs and *Lilium* by pressing upward, but nothing seems to help me. Besides if there is a thunder-storm around or if I hear music, I am still worse.”

"To change the subject," said *Natrum mur.*, "did you hear our new appellation? We have been called the 'Palpitating Family.' Well, I guess that's us. *We all plead guilty to palpitation with aggravation from lying on the left side.* This morning when I awoke I was lying on my left side and the *palpitation was so severe that it really shook my whole body.* It was the same thing before going to sleep last night."

"What you say is true," said *Natrum sulph.*, "we are a palpitating family. As for me, besides this aggravation from lying on the left side, *my heart seems to get so big as to fill the entire chest.* But I have other very annoying chest symptoms. A deep-seated catarrh. It begins way up in my head and extends downward into my chest. I cough up a *green or yellow-green, purulent discharge* and it is *very copious.* It is extremely copious. My chest seems completely filled with this purulent looking material. There is very much rattling; very noisy rattling when I cough. I must hold my chest, it is so sore and I'm afraid lest it really burst."

"Occasionally, I have a violent cough," said *Natrum carb.*, "it is very dry and worse when I enter a warm room. I heard *Natrum mur.* remark only yesterday that her cough was very annoying. She was afraid of tuberculosis until the doctor assured her that the blood-streaked mucus which she expectorated was due to simply rupturing a small capillary vessel, due to her severe cough. She complains of much tickling in the throat and her cough is worse while in bed. *Eating, drinking, even empty swallowing makes her cough worse.* Then she cannot retain her urine and she has those hammer-like pains in her head. . . . But, dear me, let's quit complaining. I'm tired of it."

"I agree with you," said *Natrum mur.*, "Seems to me we could keep this up eternally. I could enumerate many aches and pains not forgetting my intermittent fever chill at 10 or 11 o'clock A. M., and my numerous and varied skin eruptions, but let's quit. However, before we go, suppose we have a stanza or two of the song *Natrum ars.* composed last week."

Accordingly they all arose and sang—

Oh, yes, we're sisters four,

And we guess we've told you more

Of our troubles than you ever heard before.

So we'll stop, we guess, right here;  
If we don't we sadly fear  
That we'll give *you* palpitation of *your* "core."

We have troubles, yes, indeed,  
If we fast or if we 'feed,'  
If we wake or sleep, or walk or sit, it's bad.  
Yes, sometimes we're very gay,  
Yet, withal, we've got to say  
That as sisters four we're mostly mighty sad.  
(Exit all four—weeping.)

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#### UP-TO-DATE CONCLUSIONS ON THE TREATMENT OF RETRO-DISPLACEMENTS.

BY

N. F. LANE, M. D.

Clinical Professor of Gynecology, Hahnemann Medical College of Philadelphia.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 16, 1919.)

THE subject assigned me—Up-to-date Conclusions on the Treatment of Retrodisplacements—will allow me to omit, mostly, the causes, symptoms and other detail for which those interested are referred to a paper written by the author and read before this society in 1904 and published in the Transactions of that year.

It will be interesting to note if the up-to-date treatment has improved upon the methods then in vogue and in going over that paper, written fifteen years ago, it will be found that the treatment has improved very materially along surgical lines, while the medical and mechanical means of treatment remain about the same today.

At that time the surgical treatment that seemed mostly in favor was the suspension recommended by Kelly, which to-day is almost entirely discarded and the other methods just coming to our notice at that time have been so improved that we now approach a case of retrodisplacement with a degree of confidence which was lacking in 1904.

The symptoms of a retrodisplacement are due mostly to complications such as prolapsed ovaries, prolapsed ovaries and



tubes and the consequent pelvic congestion and inflammation which is usually attendant upon these conditions.

In this paper the consideration of procidentia and its cure will be omitted but those interested are referred to a paper by the author read before the Inter-state Society at Scranton in 1917 and published in the Hahnemannian Monthly of June 1918.

#### TREATMENT.

A few selected, uncomplicated cases may be properly treated in the office by the pessary with a hope of cure and others *must* be so treated for the reason that they will not submit to an operation.

A modern operation, properly performed, will give more than a reasonable hope for a permanent cure; therefore it seems to me to be the height of folly to treat patients, especially young women, with pessaries and tampons when they must look forward to continuing these treatments for the rest of their life if they are to be comfortable.

In 1904 I spoke as confidently of pessary treatment as of surgical, but today, to be "Up-to-date" I speak of operative measures with the utmost confidence and give the pessary a back seat to those who will accept my advice as to treatment. We shall always have the pessary with us, but it is to be hoped that they will be used less as time goes on.

Retrodisplacements following confinement may often be successfully treated with a pessary if treatment is begun early, as soon as vaginal involution is about completed. This is one of the legitimate conditions for the use of the pessary.

For methods of replacement, treatment by pessaries and other office methods you are referred again to the paper of 1904 which is still as true and up-to-date as when written.

I consider the treatment of retrodisplacements by the modern methods of operation as *the* treatment and ordinarily do not mention other procedures to those who in my judgment should have the benefit of modern surgical measures.

There have been many operations devised, in fact this seems to be a favorite field for "designers of operations," but they can be mostly cast aside for three or four which may be modified to suit nearly every case. It would seem from the vast number of these operations devised and which are mostly worse than useless, that the love of notoriety or a little cheap advertising was the incentive for their publication.

For all practical purposes retropositions may be successfully treated by means of the Webster-Baldy, the Gillium, Montgomery's modified operation and a shortening of the round ligaments by plication or folding upon themselves. None of these operations will interfere with a normal pregnancy.

All these operations permit treating any complication we may find in the pelvis and are not blind operations.

The Baldy is rather a favorite of mine as it gives a very strong support to the uterus, throws it well forward into its normal position and supports a prolapse ovary as none of the others do.

The Gillium draws the uterus well up toward the abdominal wall but does not throw it as well forward as the Baldy.

The Montgomery is practically an Alexander done from the inside of the abdomen instead of through the inguinal region from the outside.

This operation is perhaps the most anatomical of them all and when the ligament is strong is an excellent operation and ordinarily is preferred. However it is rather the exception to find a strong well developed ligament in these patients.

Plication of the round ligament is used as a preventive measure when there seems a slight tendency to retroversion or to temporarily hold the uterus forward after removal of the appendages where there has been extensive adhesions and considerable raw surface is left. This prevents the uterus from falling into the cul-de-sac and becoming adherent there. When the ovaries are removed and extensive raw surfaces must be left, the patient is usually best treated by removing the uterus also. The operation is often more quickly done, the raw surfaces are mostly removed, patients make a better recovery and suffer less from subsequent symptoms. In my hands it has been a most satisfactory way to manage these cases.

Finally then the up-to-date treatment of retrodisplacements of the uterus is surgical.

The discussion of theory and detail has purposely been omitted, but an effort has been made to arouse enough interest to get you all upon your feet to criticize me or to defend your own pet operation.

**CONSERVATION OF VISION.**

BY

PERCY A. TINDALL, M.D.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

It is estimated that 50 per cent of all blindness is preventable.

It has been customary from time immemorial and even in the present times for the masses of people to be governed or controlled by a few, who directed their line of thoughts and oftentimes their methods of living, which frequently was not to the advantage of the people in general. The tendency, however, of the present times is to make the individual more acquainted with his personal responsibility in the affairs of this life and it is absolutely amazing what a large thing it is to endeavor to develop personal responsibility by educational methods in the one single subject of conservation of vision. When we, who have good vision, take the time to consider the eye, we find it to be one of the most precious organs the Creator has granted us, yet in a general way give practically no heed to the care such an organ demands, until something happens.

Conservation of vision means to conserve—to save our vision—not to wait till something happens to mar or destroy the eye. The last report of the Pennsylvania Institution for the Instruction of the Blind states there were 236 pupils during the year 1917-1918. Is it not somewhat appalling to think that of these 118 are needlessly blind—due to lack of personal responsibility, ignorance, careless habits.

In children of tender years, personal responsibility cannot be required for obvious reasons and some one else must assume responsibility for them and that very likely would be their parents.

The war has brought to the attention of the nation certain menacing social facts. We have learned that one-tenth of our people are unnaturalized aliens; that on an average 25 per cent. of the men of the training camps were not able to read a newspaper or write a letter home; that one-third of the men of the selective draft were physically unfit; that there are approximately two million mental defectives in the United



States; that there is an alarming prevalence of venereal infections.

Nation-wide movements are now in formation, under the leadership of departments of the Government, but including the co-operation of the entire social organization of the country, to meet these problems, concentrating especially at this time upon the Americanization of immigrants and upon sex morality and the control of venereal diseases.

The answers to some of these questions are very simple, but the time required to carry out what the answer implies, would carry us a few thousand years ahead of our time, but we cannot wait that long, and someone comes along and proposes prophylaxis in venereal diseases and the morale of our morals is on the wane. Some of these questions are rather difficult to handle, the same as is the question of vice segregation, but such answers are only temporizing with a great and serious matter and their end is worse than their beginning. The only solution for these questions of sex morals or the increase in venereal diseases, is recognizing our personal responsibility and that developed to its highest attainment is the essence of the Golden Rule. At the present time about 20 per cent. of all cases of blindness is due to ophthalmia neonatorum; the figure varies a little from year to year. About 50 per cent. of babies born have mid-wives in attendance and some undoubtedly have only kind, ignorant, neighborly supervision. It takes many laws and many years to impress people with the fact that babies' sore eyes can be prevented and that by the use of a drop or two of silver nitrate solution in each eye at birth. It is a matter of education to make folks aware of such a thing and that will probably come before the end of venereal diseases, but it takes time. The National Committee for the Prevention of Blindness is and has been taking a large part in the effort to enlighten the general public as to the proper care of the eyes, especially the eyes of the new born.

In our own city many educational clinics are held on the subject of general medical matters, but particularly in the care of the infant and undoubtedly much good has been accomplished.

Trachoma is one of the persistent and serious diseases of the eye that oftentimes produces blindness in children. Of course, this disease is not limited to children, but its ravages are so great and so prevalent in certain localities that it is accountable for many cases of blindness or practical blindness and

other ocular disfigurement in children that handicaps them greatly in a social and material way.

In the mountain regions of Kentucky, Virginia, West Virginia and among the American Indians the disease is quite prevalent. The United States Health Service states that there are 33,000 cases of trachoma in Kentucky and of the 323,000 Indians in this country, fully 65,000 are infected. In large industrial concerns outbreaks have occurred and some of the public schools in our Southern cities have been invaded, requiring the help of the Government Health Service to eradicate the disease. The disease is supposed to be actively contagious in the stage of free discharge. The freedom in some households and in some communities, in workshops, hotels, toilets, with which people will handle the same roller towel, use the same handkerchiefs, and the same bed linen, is undoubtedly the usual methods of contracting the disease and propagating it. So that the more publicity that is given as to the way certain diseases spread, the more loathesome will become careless habits, not alone in public houses but in individual homes.

About 10 per cent. of the children in the blind schools are there because of accidents, many from toys, such as air rifles, cutting open golf balls, where the centre has contained compressed poisonous liquids.

Interstitial keratitis accounts for a little less than 5 per cent. of those in the blind schools and most of this is very likely due to neglect, or could have been prevented. The need of compulsory examination of the eyes of all school children, even before school age is reached, is one of absolute necessity if we desire to give all children an equal chance in life. The writer has dwelt upon this subject in previous papers, and even though the word "compulsory" does not sound well to most of us, is more impressed with its need as time goes on. Many parents are alive to the necessity of giving their children all advantages possible and never neglect their children's eyes. But many do neglect this matter until an easily corrected error or condition has advanced to the stage of amblyopia. Early and careful supervision is the only way to endeavor to give those with defects the same equality as those with normal eyes.

Convergent strabismus is quite a common occurrence in childhood, frequently showing itself about the second year and some means must be resorted to to correct the defect at once, for such errors are, as a rule, quite capable of correction. If one waits until the convergence is fixed or until the child is

seven or eight years of age, marked impairment of vision in the converging eye ensues. Unconsciously the eye endeavors to correct refractive errors that may be present and this automatic unconscious and needless use of nerve force, undoubtedly, produces many reflex nervous symptoms that could be easily eliminated by an early ocular examination.

There are so many ways of conserving what vision we have if we only endeavor to appreciate its worth. Efforts to maintain industrial efficiency require careful attention to the eye. An impaired eye makes the owner more liable to accident, endangers his co-workers and lessens the efficiency of the shop, decreases the production of both and as naturally follows, lessens the income. But it is a very difficult matter to make employes constantly wear protecting goggles. You can see through goggles, but not through glass eyes. Of the 2,000,000 annual non-fatal accidents in industrial occupations, about 200,000 are accidents to the eyes. Approximately 15,000 persons in the United States are blind today as the result of accidental injury of this nature. The money loss alone to these individuals and their cost and care to their relatives or the community or State is enormous.

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### A PLEA FOR CONSERVATIVE AND RADICAL TONSIL SURGERY.

BY

L. E. MARTER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

*Mr. President and Members of the State Society:*

MY only excuse for inflicting another paper on that over-written subject, the tonsils, on you, is that on the 14th of June, the day I received a request from Dr. Clay, chairman of the Ophthalmological and Otological Section, to present a SHORT (with accent on the short) paper at this meeting, I was present at an operation for adenoids. The operator had not intended to do a tonsillectomy, but the family physician, a prominent man, said, "You might as well take them out now, you'll have to do it later anyhow if you don't." This sacrifice of the tonsils in the present decade is comparable to



the sacrifice of ovaries about 20 years ago, as a cure for all diseases of women.

Several months ago a writer favored me with a reprint, wherein he advocated the removal of all tonsils in young children as a preventive of future diseases.

In dispensary and hospital work I have had many cases referred by the school medical inspectors for tonsillectomy, which, in my opinion, did not need an operation, and recently have advised accordingly, where previously I considered it my duty to operate all moderately enlarged tonsils, whether infected or not, if sent from the schools. Many theories have been advanced as to the function of the tonsils, but as yet no one has been able to demonstrate his theory to make it generally acceptable.

Dr. C. S. Raue has informed me that he has seen more cases of bronchitis in children after the tonsils are removed than in those who have not been operated, which strengthens my belief with that of many others, that the tonsils are sentries protecting the lower respiratory tract from invasion and should *not* be removed, unless diseased.

There is no more excuse for the removal of unoffending tonsils, even if slightly or moderately hypertrophied, but not infected, than to remove a normal appendix, as the hypertrophy may be the result of some constitutional disorder amenable to medical treatment. It is so very rare to find hypertrophied pharyngeal tonsils that I believe many cases of the former have been due to infection by gravity from retained secretions in the recesses and crypts of the latter, and that if the adenoids are removed the hypertrophied tonsils will decrease in size, unless infection has started in the crypts.

In many cases the infection is limited to one or two crypts on the anterior surface of the tonsil, under a fold of mucous membrane reflected from the anterior pillar and known as the plica tonsillaris, which forms a second capsule over the anterior and inferior portion of the tonsil, frequently forming a pocket of sufficient depth to admit the entire curves of a post-nasal application. This infection may be cured by separating or removing the fold of membrane and treating these crypts where the drainage is favorable, thereby conserving the tonsil.

If the infected crypts are in the upper portion of the tonsil, especially if the mouths of the crypts are in the supra tonsillar fossa, a different condition exists as the natural drainage of these crypts is downward and outward toward the base

of the tonsil. The caseous exudate is, therefore, indefinitely retained in these crypts, the mucous membrane becomes macerated, ulcerates into pockets of various sizes and focal infection with all that the term signifies, is the result. Conservative treatment has proven of no avail in these cases—the only cure is a complete, not partial, removal of the offending tonsils. The old tonsillotomy, even when combined with a punch or curette, did not, as a rule, remove the upper portion of the tonsil, which frequently extends one-half inch or more above the margo-supra tonsillaries in the soft palate. I have performed a tonsillectomy on many of these cases, which had previously been operated by others, and I have not the slightest doubt that others have operated some of my cases of like character. Under the present method of blunt or sharp dissection, as the operator prefers, followed by the cold wire snare there is no excuse, except carelessness or inability where any portion of the infected tonsil is left in situ.

I cannot refrain from mentioning a case which I saw early this month. This young lady had been operated in the spring of this year by an assistant surgeon on the surgical staff of one of our large hospitals. She had not improved since the operation, so the family physician called me in consultation. I found two large dark red tonsils covered with numerous small yellowish spots, extending far beyond the pillars, and almost touching when she gagged. Results like this are the cause of considerable doubt among the laity as to the benefit derived from the tonsil operation. Just as long as any general practitioner or any general surgeon who has not acquired the knack of doing a tonsillectomy, continues to mutilate these cases, this doubt will remain.

Other physicians do not believe the entire tonsil should be removed in children who have not reached the age of puberty. To these objectors I can only say that any tonsil or part of a tonsil which is infected and cannot, therefore, perform its normal function, is not only a useless organ but a positive menace to the health of the child if allowed to remain in the throat.

**SUGGESTIONS FOR GENERAL PRACTITIONER IN EYE CONDITIONS.**

BY

A. CLEMENT SHUTE, M.D., POTTSTOWN, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

PERHAPS no condition presents more often than the inflamed eye with a foreign body present, not, however, till there have been attempts to remove by others when most surely the eye is very sensitive to light. Are you prepared to examine such an eye easily and promptly, and to determine the cause of trouble, and if a foreign body is present to remove it with the minimum of discomfort to the patient? Of course, if there be an embedded foreign body you will use a local anesthetic after which permit me to suggest for convenience of observation an instrument not found in any catalog but sold me by a vendor of surgical instruments. This is a loop of piano wire one and one-half inches by three quarters of an inch set in a handle six inches long at an angle of forty-five degrees, and the whole nickel plated. With this it is very easy to hold open the lids for a full and complete inspection as the loop rests on the lids at a point where there is no inflammation and slight pressure holds the lids open at one's will. In children is this of especial value as once the eye is open and this on the lids perfect quietude is assured. Of course, the magnifying glass is necessary as well as a good light in removing foreign bodies. I find the glass attached to head band most convenient, leaving the operator free with loop in one hand and spud in other. We must be doubly careful to sterilize the spud before touching the eye as the attempts of the inexperienced to remove foreign bodies with something that is not sterile results in many cases of infection.

The inflamed eye from whatever the cause is likely to have boric acid solution used or recommended every time. Permit me to suggest something different and more efficient which you as medical men can use to your advantage. Triturate with your boric acid powder enough hydrastine sulphate (not muriaticum) to give a decided yellow color, using this powder to make your solutions that you give your patient and they will thank you and appreciate that you have something other than boric acid for use in the eye as there is no condition where in-



flammation is present that this solution will not give better curative results. I always carry this yellow powder in my medicine case and have found it of much value in the irritating cough following the "flu" of 1918. Besides it gives some color to the water when used and there be those still living in the year 1920 that think there is virtue only in medicine when the eye sees it.

In inflammation of the iris and cornea permit me to remind you that it is important to use atropia locally and at the earliest opportunity as well as shielding the eye from light entirely. For a convenient sterile application to have the patient use in the eye I have found the collapsible tubes of remedies put up in vaseline a fine thing not only for the patient but for peace of mind of the physician. They can be purchased in one-eighth ounce sizes and it is easy to instruct the patient to express a small quantity between the open lids, then to close and gently massage the upper lids and thus distribute the remedy over the entire eye. We can purchase in this form many drugs. The ones most used are zinc acetate for simple inflammation, yellow oxide of mercury for more obstinate cases, atropia for its effects in dilating the pupil, argyrol just the thing to use in the eye of the new-born babe, or if you prefer argentiform, copper acetate the ideal thing to use locally on the inverted lid with the little finger where there are granulations present.

For any case where inflammation is persistent, in addition to the local remedy and the indicated homœopathic remedy internally you will assist nature to a cure by the use of the high frequency glass electrode used as warm as can be borne five minutes daily and less often as improvement takes place, and let me urge all who have this modality to be sure and use it.

Pterygium is something the patient can see growing on the eye and will most surely worry about till something is done. For this use a solution of specific thuja tincture applying locally directly with cotton saturated on probe twice weekly. You will see the whole thing fade away and thus avoid the use of the knife.

Chalazion, small tumors that form on the upper eye lid, have yielded to the local application of Kennedy's white pinus canadensis applied daily by the patient using the finger to rub well in. Again let me remind you of the value of dionine, 10 per cent. solution, in scar tissue of the cornea, assuring you that if you will persist the same will entirely disappear.

Styes are sometimes very persistent and annoying. You

can assure such cases that the lesions will entirely disappear if they consult an oculist and have the full correction of visual defects. Here let me repeat what has been published before, "No optician or optometrist ever made a scientifically accurate correction of refraction. He cannot do so even though he be honest and skilled. Did you ever hear of an optician learning to fit glasses from an oculist? One week in an oculist's office would prove to him that no one but a medical man can do refraction." Yet may we not give refraction some attention with our general practice? And where skilled oculists are not at hand, do work that will be a credit to the profession, as it is the medical man alone that can put the eye at rest with the cycloplegic when it is possible to get the full correction and only then.

But recently I have noted that the journals published for the opticians are not confining themselves to the correction of vision with lenses but are giving all the text-book descriptions of the different diseases of the eye with colored plates in detail and adding the medicinal treatment. So that these gentlemen may be at least familiar with what many general practitioners are hazy upon and surely with this knowledge at hand they are going to avail themselves of it, and we find even in this State, where it is against the law, they are sending patrons to the druggist with a slip naming the remedies that the druggist supplies and gives directions to use.

It would seem that we as medical men should yearly take up the eye conditions that are likely to be met and make them the subjects of papers so worded that they would be plain to all, so that the general practitioner would be better fitted to give proper treatment promptly. Articles published in the journals are generally read while the text books remain on the shelf.

#### DISCUSSION ON EYE AND THROAT PAPERS.

DR. GILBERT J. PALEN, Philadelphia: Dr. Marter's paper was particularly interesting, because he has advocated care in the treatment of tonsils. I have advocated conservatism in the treatment of tonsils for years, and know the trouble that the doctor has in trying to give conservative treatment. The laity have been educated by the specialists to think that the tonsils should come out, but there is too much tonsil surgery done. It is an advantage to know the cases that should and the cases that should not be operated on. I think that a good

many cases of follicular tonsilitis in children are due to adenoids. I have good reason for saying so. I operated on a series of cases in a home of which I had charge. Forty cases of follicular tonsilitis in which we took out the adenoids alone, and 40 cases in which we took out both the adenoids and the tonsils. In the former, there have been only a small percentage that have had trouble with the tonsils later. I think, therefore, that the other cases would not have had diseased tonsils later, if the adenoids alone had been removed. There are, of course, some cases in which the tonsils should be removed; because they are an absolute detriment, interfering with speech and deglutition. Again, we have a type in which we have ear conditions present; and we have tonsils with a large lobe in the upper tonsillar fossa, producing pressure on the eustachian tube and causing deafness in children. But I think that in many cases of follicular tonsilitis, if the adenoids are removed with all the tissue in the fossa of Rosenmuller, all that is necessary will have been done for these children. There is nothing that has a greater influence on hearing than the fossa of Rosenmuller. In a boy with adenoids, running a temperature with no apparent reason, and so deaf that he could hardly hear a conversational tone, the removal of the adenoid tissue in the fossa of Rosenmuller caused a clearing up of the condition, with cessation of the temperature and a return to normal within two or three days after the operation. So the conditions in the fossa of Rosenmuller are very important. We find these same conditions in older people whose adenoids have disappeared, leaving bands of tissue where they have suppurated. I believe that the doctor was right in bringing out this subject, because there is too much surgery done without examination, and without rhyme or reason for the work done. The other papers that we have heard today have been excellent, but I do not know of anything that I care to bring out with reference to them.

DR. IRWIN D. METZGER, Pittsburgh: I was especially pleased with Dr. Tyndall's paper, because he brought out the policy of conserving vision. The greatest thing that a doctor can do is to make efficient the natural thing that exists. Instead of bringing back sick people to health, it is much more laudable to intensify the natural conditions that prevent disease.

There are two eye conditions that we ought to get rid of—amblyopia ex anopsia and myopia. The former is due to the fact that the eye has not been used; the perception of one eye being easier than that of the other, it is ignored and remains undeveloped. If we can impress on the general practi-



tioner the fact that the eyes of every child should be examined not later than at the age of three years, we can prevent a great deal of this condition. It is remarkable how many adults have this condition. This was shown in the examination of eyes in the service. A person with single vision is a dangerous person on the streets. A person with single vision should not drive an automobile. A person reading with a single eye cannot look at the audience and then back to the page, because he loses his place. A person driving an automobile cannot look at his car and then on the road, and change the focus quickly.

Myopia should be prevented, because it is nearly always due to the fact that excessive convergence has caused indistinct vision in childhood. To enlarge the image, the object is brought close; and this causes an elongation of the eyeball. That condition should be prevented by detecting the excessive convergence early and correcting it by proper refraction. This should be done in children not later than the age of three years. Just as you examine for tonsils and adenoids, so you should examine for these possibilities.

Dr. Shute presented an instrument, a speculum, which I thought admirable. It reminded me of one that I have in my pocket, which was presented to me by Major Wilder. It is a lid elevator, which is very useful in the office. You can evert the lid of any child without effort. Every oculist should be able to do that; but it is quite disconcerting not to be able to do so, and this is exceedingly handy to have in the office.

DR. HOWARD TERRY, JR., Phoenixville: I just want to comment on Dr. Marter's paper relating to operations on the tonsils by the inexperienced. I have had several experiences where patients have been operated by novices or the untrained with very unfortunate results.

DR. P. H. GERHARDT, Reading: I should like to make one point in reference to the gas cases. In our hospital we had possibly four or five hundred gas cases. Some were blind three or four days, and some a week. Of all these cases, the four or five hundred gas cases, only two developed corneal trouble. One had poor vision in the left eye.

In regard to the treatment, we found, and I think that the four ophthalmologists agreed, that after experimenting with various things, from boric acid down, that usually in the first few days cold applications produce good results; but that after that (we got our patients from six to forty-eight hours from the front), argyrol, made up every second or third day, was better than olive oil or bicarbonate of soda. We used hot applications after the second or third day; and nearly all cases cleared up

quickly, except for the photophobia. We had five or six cases of photophobia that continued five or six weeks without improvement. The inflammation went away entirely and the eye became normal, but the men refused to open their eyes. We examined them carefully after four or five days, and several times afterwards. The retina seemed perfectly normal in all the cases.

There is just one other point that I want to make, regarding the obstruction of the nose and infections of the mucous membrane, in relation to carriers of the disease. When I was at Camp Jackson I examined the 81st Division. There, you will remember, we had the most severe epidemic of meningitis that any cantonment has had. It was particularly prevalent in the 316th Field Artillery, made up of men from Kentucky and South Carolina. We found that we had a great many carriers there, between three and four hundred at all times. Fifteen or twenty men would come every day, and about the same number would clear up in that time. We had not much trouble in clearing up the carrier, if the structures were normal, by spraying with Dobell's or Dakin's solution. We began with a ward of fifty patients, and sprayed each one, to clear out the condition, and let the nose dry while we were attending to the others. Then we used dichloramine-T. This treatment was all right, except where there were nasal deformities. These cases did not clear up until the spring, when we got the good sunshine and no more rain. They cleared up then, of their own accord. In March and April of this year, the 79th Division and the 319th Field Artillery again came through; and we developed cases of carriers. It fell to my lot again to clear up these meningitis carriers. We tried again everything, from dichloramine-T to every other preparation; and in that climate, where it rains every night, we cleared up all the cases that had no deformities. But the same cases that we had at Camp Jackson, where they had an obstructive septum and other nasal conditions, would not clear up. I suppose that when they got where they had sunshine every day, they cleared up of themselves. We should remember that where there are deformities of the nose and upper air passages, the men become carriers and remain so, unless the condition is cleared up.

DR. J. V. F. CLAY, Philadelphia: I wish to emphasize one point that has been brought out, about the fossa of Rosenmuller. I believe that too little attention is paid to this area. Someone said that the worst work we do is our adenoid work; because we cannot see it, but rely on our sense of touch. In cases in which we fail to relieve our patients after the adenoids have been removed, I believe that if we were to go over the case, we should find that the trouble is in the fossa of Rosenmuller.

Another thing that I wish to refer to was mentioned by

Dr. Palen, the series of cases in which both adenoids and tonsils were removed in one-half of the cases, and the adenoids alone in the other. This is interesting, because the patients were in the home for a number of years, and could be observed for quite a while after the operation.

DR. J. W. STITZEL, Hollidaysburg: Dr. Shute mentioned the effect of dionin on scar tissue. I have seen a case in which the effect was marvelous. The patient was an old gentleman who had not been seeing out of the eye for a long time. I was surprised that in a very short time he came back and said that his vision was improving, even after he had been blind in the eye for a number of years. In his paper Dr. Shute recommended 10 per cent. I have never had the temerity to use more than 5 per cent., and have the patient use it himself. If Dr. Shute begins with 10 per cent. I should think that very few patients would use it the second time, because the reaction would be too great.

DR. CLAY: My experience has been the same. If you have not tried potassium iodide for the purpose of clearing up corneal scars, try it.

DR. J. G. ALEXANDER, Philadelphia: I wish to say a few words with reference to Dr. Marter's paper. I have experienced the same thing that he has with reference to physicians' sending these patients to the hospital for the removal of adenoids; so I think that it is well to examine them carefully before operating, because you frequently find no adenoids whatever to remove, and therefore, operation is not indicated. In many cases the lesion is intranasal obstruction, mostly in the form of a deviated septum, which is best treated by submucous resection.

With reference to removing the tonsils, I scarcely believe that many responsible specialists would advocate recklessly or generally the removal. Certainly, a careful examination should be made of the tonsils, and the diseased portions selected to remove. On the other hand, the tonsil is frequently so diseased that it requires close observation to find which are diseased and which are not. On the other hand, the doctor mentioned something about not removing hypertrophied tonsils. I infer that he means that when the tonsils are not diseased, removal is not indicated. I have always considered a hypertrophied tonsil as diseased. Although there are periods, perhaps, when a hypertrophied tonsil may have entirely recovered from any previous inflammatory attack, nevertheless, relapse is always imminent.



**MALARIA.**

BY

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Assistant Demonstrator of Pathology, Hahnemann Medical College of Philadelphia.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 19, 1919.)

ALTHOUGH a vast subject, I shall attempt to impress a few essential points on the general outline of this parasitic disease, especially as to the way it appealed to me while pathologist at a B. E. F. hospital during the past war. Most cases had their primary infection either in Salonica or South Africa and a few in France. Many of the latter may be said to have received their primary infection elsewhere.

DEFINITION.—An infectious disease caused by a protozoan parasite—the plasmodium malariae—and characterized in its acute phases by chill, fever and sweat with periodic intermissions and chronically by splenic enlargement, anaemia and emaciation.

ETIOLOGY.—It may be stated that the source is man from which the mosquito derives a parasite and the other conditions which are favorable to the life of the mosquito, such as heat, humidity and undisturbed bodies of water. Persons living in high lying localities are less liable to infection than those living in low lands because the mosquito does not rise high above the ground. Malaria is more apt to be contracted at night than during the day because most species of the genus anopheles are nocturnal in their habits. Men returning from Salonica would especially quote this latter saying as absolutely true.

PATHOLOGY.—The mosquito anopheles may be said to give rise to three types of malaria fever: Tertian, quartan, and estivo-autumnal; each showing a distinct malarial parasite, the sexual cycle "sporogony" taking place in the female mosquito, a period of which lasts from eight to ten days, and an unsexual cycle "schozogony" taking place in man.

Microscopically they differ from each other by the number of spores in the red cells of man, the tertian having 15 to 26, the quartan 6 to 14, and estivo being a more rapid form contains very little pigment and segmentation does not take place in the peripheral blood but in the spleen and other internal organs of malarial fever other than estivo autumnal, and

the corpuscles seem, in such cases, to be also somewhat smaller.

My own experience with patients having tertian fever particularly in chronic cases was that the ring form hyalin bodies were always very easily found in the blood; three or four forms may even be found in a single red cell. The pre-segmentating forms may be said to rank second in order to be found in chronic cases of malaria. Most cases were, of course, as stated, chronic cases, and most cases, to my knowledge, seem to have been bitten by not only one mosquito but many, and in the blood of such cases different stages of the cycle of the parasite in the red cell could be seen; in such cases the chill, fever and sweat, with its intermissions, were never a regular periodic condition. In many cases where a patient was having a chill the ring form bodies could be found in abundance and immediately following this, or after the sweat pre-segmentating and segmentating forms could be seen. The stain I used was that of Leischman, a stain similar to Wright's.

PATHOLOGICAL CHANGES.—Spleen: enlarged, particularly in the chronic cases, and must be differential from that of rickets typhoid, cirrhosis of the liver, splenic anemia, leukaemia, Hodgins disease, amyloid, abscess and malignant disease; but, I am sorry to say, that most of these forms can only be detected from postmortem examination.

The blood picture, as already discussed, is the more important. The leucocytic count likens itself, in the acute stages, with that of typhoid in that there is a decrease in the number of white cells of the blood due most likely to the mechanical destruction of the corpuscles by the parasite. The liver shows only pigmentation.

DIFFERENTIAL DIAGNOSIS.—1. *Typhoid*; 2. *Yellow Fever*, slow pulse, albuminuria, bloody vomit, no splenic enlargement. 3. *Leukemia*, with its characteristic blood picture. 4. *Acute Mania*, high temperature, low leucocyte count. 5. *Tuberculosis*, particularly with tubercular peritonitis. 6. *Black-water Fever*, found in persons who have had malaria, or who are still infected with the parasite. It is a violent and rapidly fatal disease in which the most striking symptom is a passage of almost black urine, the color being due to the presence of hemaglobin. Diminution of the urine to complete anuria may follow. Intoxication is severe; there is rapid blood destruction and profound anemia follows quickly. The spleen is greatly swollen and tender, there are vomiting and intense

jaundice and fever; recovery may occur without conferring any immunity, but rather predisposing to another attack. The patient, in most cases, dies from exhaustion, suppression of urine and rapid blood destruction. It has been stated that it is due to an intense poison, but no such poison has been demonstrated. In some patients the administration of quinine will bring on an attack, but there are many cases in which quinine is said not to have been given. Let us conclude, therefore, that malaria produces a condition which predisposes to blackwater fever.

Having witnessed two such cases, neither of which was induced, to my knowledge, by the administration of quinine, although both patients were from the tropics, and had taken oftentimes large doses of quinine, having had severe cases of malaria, both of these cases developed rapid blood destruction haemoglobinuria and collapse within 48 hours. The suppression of urine was not marked in the beginning and the malarial parasite could not be demonstrated in the blood smears.

TREATMENT.—The administration of quinine and its derivatives has been pronounced by many the only successful treatment, both in the acute and the chronic stages of the disease. A perfect set of laws have been laid down as to its exact administration. The dose of quinine depends entirely upon the individual case, as to the type of fever, whether benign or otherwise. Bad results are often due to improper methods of administration. When talking with a colonel of the British Army who had lived in the tropics for 28 years, he laid down the following method: That before a paroxysm a thorough emptying of the bowels must be secured and a large dose of quinine also to be given before the paroxysm. It must not be given during the paroxysm. For chronic cases and those living in malarial districts or those who have had malaria not less than 60 grains of the salt of quinine must be taken weekly at regular intervals. In severe and pernicious cases the administration must be done as quickly as possible by injecting at once into the tissues of the thigh or buttock a soluble salt, such as the dihydrochloride of quinine in 30 grain doses. Let me state that there was not a chance at any time to try out the indicated homœopathic remedy.

Salvarsan has been employed in the treatment of malaria and has often proved successful, but in cases in which I have



seen given the same the quinine has done the most good. This brings to mind the possibilities of the Wassermann reaction in the diagnosis of malaria and positive reports have been given in cases of malaria during the febrile stage or when the parasites are present, but I have never witnessed personally a positive Wassermann in such cases.

#### DISCUSSION.

DR. A. KORNDORFER, Philadelphia: I have listened during the past fifty years to the same old story, that quinine is the one and only cure for malaria. In my early practice I was led to make the trial, and that, too, with the approved therapeutic doses, but it failed me. I then made a careful study of the disease in its yearly return, and further of the characteristic symptomatic picture of each individual case of the disease coming under my care. From such a study and analysis I was led to a strict therapeutic individualization and with correspondingly satisfactory results. I will not attempt to enumerate the remedies employed, but will state that capsicum, natrum muriaticum, arsenicum, and eupatorium perfoliatum were among the most frequently indicated.

In chronic malarial conditions natrum muriaticum is surely one of the most important remedies.

"Bonninghausen's Homœopathic Therapia of Intermittent and Other Fevers," which I translated nearly fifty years ago, gives reliable indications for a large number of proven remedies, and from which I derived much assistance in the selection of the true similimum. Remember, always, that when you employ the distinctly indicated homœopathic remedy, whether it be natrum muriaticum, capsicum or any other, you surely can count on curative results.

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RENAL LITHIASIS AND CALCULUS OF THE BLADDER IN INFANCY.—Riverola (*Semana med.*, 1919, xxvi, 18) states that this condition is frequently encountered in Buenos Aires among infants, being more common in males than in females. Bladder calculus, he considers to be but an incident in renal lithiasis. Most authors agree in thinking that the uric infarct found in the kidney of the newborn, due to a surcharge of uric acid, may not all be removed in the early weeks of life, as is usual, because the urine may not be sufficiently solvent; and in that case may form the nucleus of subsequent stones. The stones may remain in the kidney, pelvis or ureter, but may reach the bladder, which is common in infants. Riverola treats the condition by lithotripsy or litholapaxy when possible. When, however, the stone is large or the bladder is infected, he makes a bladder section. Both methods have proved satisfactory in his hands. Hygiene, and diet particularly, should receive attention after the removal of the calculus.

## GASTRIC ULCER.

BY

A. B. WEBSTER, M. D.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

GASTRIC ULCER is not a disease for the specialist alone. On the contrary, it demands the special attention of every practicing physician. It is not an uncommon disease; in fact, it is much more common than we will allow ourselves to believe. The consequences of this malady are often of a very serious nature, and in some instances are due to our delay with the hopes that the patient will improve with some of our remedies for indigestion. Many cases have been treated for "acute indigestion" when there has been evidence of a beginning "perforation." These are often times looked upon as being nothing more than some indiscretion in diet.

Many divide gastric ulcers into two types, but it seems to be more explicit to divide them into three:

*First.*—The simple weeping area or erosion.

*Second.*—The acute and chronic varieties. (These should come under one type.)

*Third.*—The malignant ulcer.

In my opinion, there are a great many "simple weeping areas" or "erosions" on the mucous membrane of the stomach that often take care of themselves and heal without any further trouble. Of course, this is providing the patient uses any care at all in the selection of his diet. There is not so much to be said about the cases belonging to this type, except the fact that they produce slight hæmorrhages and other gastric symptoms that will be mentioned later. The acute ulcer, as a rule, is not so large and can develop on almost any part of the stomach from cardia to pylorus. It seems to be more frequent on the posterior than on the anterior gastric surface. However, it is not unusual to find two ulcers directly opposite each other, and from this fact, many have been led to believe the theory that the cause was due to some variety of infection. They are especially found in young, anaemic women under 30 years of age, and are usually conical in shape, due to the fact that each successive coat is destroyed to a lesser degree than the one internal to it; therefore, giving it a funnel shape. The edges

of all acute varieties of ulcer are soft, very much inflamed, and somewhat elevated. These acute ulcers have been healed without much difficulty just the same as in the previous type of which I have spoken, as is evident from the number of radiating cicatrices often found during "post mortem" examination.

Unless this variety or type is found within the pylorus, they rarely give rise to stenosis. If occurring within this area, however, they may give rise to retention and, therefore, demand immediate interference. This is rare, but is a thing to be considered. Haemorrhage is common in a great many of these cases, but hardly ever results fatally. The most prominent symptom then is pain, haematemesis, tenderness and hyperchlorhydia. Pain is usually epigastric and localized, but may radiate to the back, to the angle of scapula or even to the shoulder or to the left of spine from the 10th to 12th vertebrae. Pain usually comes on after eating and often persists until after the stomach is empty. It may be associated with vomiting, which relieves almost immediately. Liquid food and alkalies relieve by neutralizing the gastric secretions. Pain between meals is at first intermittent, but finally becomes continuous. Pain after food varies according to the location of the ulcer—cardiac end immediately and sometimes even found during swallowing. In this case, of course, it would be very high up; in the pylorus one to two hours after eating; in the duodenum, as you all know, still later. Tenderness on either side of midline is observed, according to the location of ulcer.

Let us next consider the chronic ulcer. This may be very large, irregular in outline, thickened edges, puckering the stomach, and producing stricture or hour-glass contraction. Three-quarters of this type are near the pylorus or on the lesser curvature, producing stricture or hour-glass contraction. The majority of them are found in men of middle life and also in advanced life. Some have gone so far as to claim that three-fourths of this type are found in men advanced in years. Haemorrhage in this type of ulcer is not uncommon and may often prove fatal, due to rupture of one of the branches of the coronary artery, or we may have severe bleeding which may arise from varicose gastric veins in the neighborhood of the large indurated gastric ulcer.

Haemorrhage does not exist in all cases, so one should not wait; a diagnosis should be made without haemorrhage,



just as that of gall-stone disease is made without jaundice. Who will stand back and say we cannot have gall-stones because jaundice does not exist? And how often have you heard that expression?

There is a class of ulcer cases not so large but quite distinctive and extremely difficult to diagnose. Clinically they are diagnosed gall-stones. These ulcers are often duodenal or pyloric, but may be gastric. They seem to have no complications save frequent perforating tendencies, yet a part are not reported at operation. Often the only symptom complained of is sudden, acute, short attacks of epigastric pain, rarely with radiation, but which may radiate to the back if posterior perforation is impending.

Recovery from pain is usually sudden and complete, typically gall-stones in character and no other rational diagnosis can be made, save by the aid of the X-ray.

In many chronic, complicated ulcer cases with perforation, the early history often gives the solution. In gall-stones, the grouping of symptoms is quite different. Here the symptoms appear in acute attacks of short duration, usually from a few moments to a few hours, but one attack is the rule with an intermission of hours, days, months or years of normal health, if the case is a simple and uncomplicated one. The attack comes suddenly, often without any warning. Quite as characteristic as this suddenness of onset, is the abrupt cessation even at the height of pain, followed by the immediate return to health.

Pain is the great and constant symptom. The chest and abdomen may be included in its severe grasp. It is bearing, pressing, or often expressed by patient as a "queer agony," or it may be lancinating, severe and terrific, approaching the pain of gastric perforation. Pain appears without relation to food in the greater number of cases, coming before meals, after meals or when abstaining; not caused or relieved by food in the majority of cases.

The bloated, distended and bursting sensation that many experience is due to the character of pain, its field of radiation and the spasm, rather than to the actual gas present. Chronic gastric disturbances are prominent in such cases as chronic gall-bladder trouble with adhesions, duct obstruction, perforations, duct infections, contractions and perhaps pancreatitis. The whole picture is so closely that of chronic ulcer with per-

foration complications, that a differential diagnosis cannot be made. The combination to the diagnosis lies in developing the early history which often shows clearly the early, clear-cut ulcer syndrome or the typical train of gall-stone symptoms.

The differential diagnosis then is not so essential, as these patients are unquestionably surgical and an operation in experienced hands will correct this condition. The periodical attacks of ulcer are the day-by-day attacks or symptoms coming on from two to five hours after eating, and relieved by alkalies—the duodenum by food, vomiting and irrigation. Gall-stone attacks are not due to or eased by food, and suddenness of appearance or disappearance is noticed.

The percentage of perforations in chronic ulcer is 26 per cent., and it is in this group that we find our greatest number of errors.

Jaundice with gall-stones, 25 per cent.

Haemorrhage in gastric ulcer, 25 per cent.

Other symptoms being equal, a question of gall-stones and ulcer arrives. Let the date of the first symptom decide. If the symptoms began when the patient was young, let the diagnosis of ulcer be favored; if in late life, give that of gall-stones the preference. Latent ulcers are not so likely to be carried over in later life as latent gall-stones.

When attacks come two or more times a day, repeated in a measure day by day without food relation, even when acute like gall-stones, guard carefully the diagnosis. It is much oftener ulcer with perforation than gall-stones.

If a patient from 35 to 50 years has had gastric symptoms for years and has not developed jaundice, fever, chills or a large liver, diagnose ulcer, especially if the acids are high.

In prolonged spells with burning attacks daily, ulcer, not cholecystitis, is the rule. Pressure or posture may ease ulcer pain, rarely gall-stone pain. High acids in many cases, point to ulcer with varying spells of short duration, irregular food distress or pain, no appetite: even with gas, belching and vomiting, and good acid contents, look out for appendicitis. Appendicitis gives a gastric history or gastric symptoms, but not an ulcer syndrome.

The history of a duodenal ulcer is as a rule, longer than that of a gastric ulcer. There is less chance of a duodenal ulcer being latent. The higher the acid content, the lower the ulcer. Pain is more frequent in duodenal ulcer. Haemorrhage

is more frequent in gastric than in duodenal ulcer. Ease before next meal.

With high ulcers there is often regurgitation, giving the patient a burning sensation, also bloating and pressure; more frequent in gastric. Continuous symptoms are much more common in gastric than in duodenal ulcer. Patient is easier with stomach empty.

What can we then say of a malignant ulcer, or ulcer carcinomatosus? This is, without a question, in the minds of most of the authorities today, that a malignant condition has become implanted on a "simple, benign chronic ulcer," and, therefore, met with especially in men at cancer age. This being the case, many of these chronic benign gastric ulcers take on a malignant formation. What are we then to say regarding the treatment of ulcers? This disease in the past has always been considered more or less of a medical subject, but at the present time it appears to be more of a surgical condition. If it is a fact, however, that chronic benign ulcers develop into malignant ulcers, there is only one procedure to follow, and that same procedure, without a doubt, should follow in most cases of gastric ulcer, that is a complete removal of the focus. Are you, then, to stand by and allow your patient to go on with gastric symptoms until the "hand of death reaches out and claims its victim;" or, do you give the patient the benefit of a simple laparotomy with the privilege of exploration and in the majority of cases discover an ulcer which might later become malignant?

Many, many cases of inoperable carcinoma of stomach have given just such a history that they have been treated for stomach trouble for years, and when they fall into the hands of the surgeon, it is too late.

The only operation that can then be worth considering is that of "palliation," whereas if the patient is brought to the table early in the stages of this disease, he can be cured by a radical procedure of a simple benign gastric ulcer. Examine any healed ulcer of the stomach and what do you find? The mucous membrane is, without a doubt, healed and cicatrization exists, and radiates in all directions, giving a hard, indurated mass varying in size from a quarter to a silver dollar which stays there without being absorbed. This is the kind, then, in many cases that goes on to malignancy. This is the kind, then, that should be removed by extirpation. This is the variety that



should give you hardly any mortality in your operative work. The operation is very simple and with a little experience it is very easy to do a complete resection of a gastric ulcer.

What is done, then, for a perforated gastric ulcer of which we see so many? Why do they perforate? They perforate, gentlemen, to a large extent, because they have been under treatment and observation a long time for that vague symptom known as "indigestion." What happens when they perforate? The physician, as a rule, claims the patient has bowel obstruction or acute appendicitis; so many are misled with an acute perforation of the stomach. Immediately following the perforation there is severe shock and collapse. In a short time the patient recovers from this if the doctor is called, and gives a hypodermic, and returns in two or three hours, finds improvement, with the result "I'll see you to-morrow." This poor fellow then, with a hole in his stomach, with the peristaltic wave of the stomach pumping its contents into the peritoneal cavity, goes on for ten, twelve or thirty-six hours, and then he becomes very much worse, because he has developed a septic peritonitis. This is the time, gentlemen, when you act and say, "This patient should be operated on immediately, if you want to save his life," and this is the reason then why the mortality is so high; it is the delay! delay!! delay!!!

The mortality, in my estimation, in the majority of these individuals with perforations, operated within 12 hours, should be almost nil, barring complications; operated within 16 hours, the mortality commences to go up; operated within 24 hours, the mortality is very high; operated beyond 24 hours, the mortality is almost 100 per cent.

What shall we do for a perforated ulcer in the way of operative treatment? This is a question which varies a great deal in the hands of different operators. Some of our most prominent surgeons claim that if a perforation is sutured, the ulcer will heal and the patient get well. What have you done if you only sutured up his perforation? You have left the condition that caused his perforation. He has still his old, hard cicatrix which in a great many cases goes on to malignancy. This is the time, in my estimation, for radical procedure, and I believe, as many others believe, that it is the proper time to resect such an ulcer.

The treatment as followed today is "gastro-enterostomy"

with or without excision of the ulcer. This procedure can be modified a great deal at present. If the ulcer is above the pylorus far enough so that repair following your resection will not in any way encroach upon the natural outlet of the stomach, in my opinion it is not necessary to do a "gastro-enterostomy."

The method recommended by Mayo of using the electric cautery seems to be the ideal procedure in these cases. It simplifies your operation by controlling haemorrhage and is also a quicker procedure than when the resection is done with a knife, and also has the advantage of destroying any possibility of beginning cancer cells in this area.

Some judgment must be used, however, if the patient is in a serious condition; should this be the case, follow out the quickest method possible in order to get your patient off the table—but it takes a very few minutes longer to resect an ulcer than it does to sew up the perforation.

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## INDICATIONS FOR AND RESULTS OF BONE PLATING AND INLAYING.

BY

R. C. CASSELBERRY, M.D., CHESTER, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

For several reasons this paper will be disappointing. The first evidence thereof is that it is short, and that alone to a scientific audience like this one before me is enough to condemn it. There are several reasons why it is short, but as these reasons are not "fool proof" I refuse to commit myself.

What I have jotted down here are some observations and experiences we have had in the use of bone inlay, bone plates and screws, at the Crozer Hospital. We have endeavored in every way to be conservative but not lax or dilatory. We have striven to keep from adding to that ancient collection in the valley of dry bones, referred to by more eminent personages than your humble servant.

Fracture surgery may be extremely fascinating or just the reverse, according to how we approach it and apply ourselves to the proper reduction and retention of same.

With the invaluable help of the Roentgenologist and the means we now have at hand for the proper diagnosing and

reduction and retention of fractures, there is very little excuse for impaired function or deformity, unless there be considerable loss or destruction of bony structure or some constitutional dyscrasia.

Each individual fracture should be studied as to the character and location of the fracture and the best method to be employed to hold the fragments in apposition.

X-rays before and after reduction are of the greatest value in making clear the deformity we have to deal with and show us whether we have been successful in our reduction and retention.

After a tedious, painstaking and probably exhaustive hour, does it not almost give a thrill of pleasure to look at the x-ray plate and find that we have obtained perfect apposition, a later x-ray depicting the callus, cementing the fragments, thus giving the patient as useful a bone as he had before broken. Then we feel that the work was well done and our gratification cannot be measured in a monetary way.

If, however, we are careless and do not make a careful study and apply the best method for retention and the x-ray shows a deformity, which should not be, our feeling of pleasure is turned to one of chagrin and we are open to justly deserved criticism.

In uncomplicated, simple fractures there are a variety of splints and appliances which are available for the proper retention of the fragments. It is only a question of the complete reduction and using the most comfortable splint or splints in order to secure good results.

Experience is always a wonderful teacher and nowhere is its value exemplified more than in this line of work. Former mistakes are not forgotten and not apt to be repeated.

In severe fractures, compound, comminuted, spiral, etc., where external splints are hard to apply in order to maintain reduction, it seems advisable to use some internal method first and support this with the external appliances afterwards.

There is so little risk under the modern hospital technique in doing this and the results are so uniformly satisfactory, so much time is saved to the patient, there should be no hesitation on our part, after the character of the fracture shows it as the kind that calls for the combined methods to employ them.

No branch of surgery requires clearer, firmer judgment,



combined with strict aseptic technique than that dealing with open fracture work.

Skillful and co-operative assistants are of inestimable importance and I wish here to thank Doctors Van Keuren and Clark for the "team work" which they have rendered, for it is mainly by this "three man team" that we owe our success at the Crozer Hospital.

In citing a few of the cases, the credit belongs not to one man but to the "three man team."

Case 1. Initials J. D.—Male, age 56. 5/14/18. Heavy weight fell, striking head and shoulder, crushing him to the ground. Laceration and contusions of shoulder and body. X-ray shows fracture of external and internal malleoli of right leg. Oblique fracture from lesser trochanter downward and outward about two inches. Oblique fracture of shaft, parallel to upper fracture, four inches below. Three inches shortening rotation of lower fragments inward. This shows an upper fracture or fragments complicated with an oblique or what was really a spiral fracture below, making a very nasty condition to deal with. He was put up in a plaster cast of both thighs, including pelvis.

6/12/18. X-ray shows considerable deformity. Patient etherized and long incision made, exposing seat of fractures. On account of the large loose fragment above and spiral character of lower fracture, it was deemed advisable to use a large plate rather than inlay because both conditions would be overcome with plate. The plate screwed in place held the bone in perfect alignment. Two strong kangaroo tendons were passed completely around fragments and snugly tied.

7/25/18. X-ray showed position good, with lots of callus. Made uneventful recovery. No infection. Patient discharged 8/27/18. Walking with plate in position and instructed to return if any trouble should arise. Up to date he has not returned.

Case 2. Initials F. H. Male, age 44. 10/1/18. While working 6 inch shell on lathe, slipped and left arm caught in machine. Comminuted fractures of both bones of left forearm, upper third left humerus—sub-glenoid dislocation. Deep laceration of chin. Dislocation reduced, fractures reduced and put up in splints. Chin sutured.

11/13/18. X-ray shows non-union of humerus. Fore-arm united with slight deformity.

11/20/18. Incision over fracture of humerus and bone plate applied.

Returned 3/15/19. X-ray showed non-union of humerus.

3/18/19. Incision and fractured ends exposed. No callus. Eburnated ends chiseled off and graft from tibia inserted. Healed without infection. Later x-rays showed the graft taken and covered with callus but not much callus on under surface of fracture.

There has been a gradual increasing improvement in the usefulness of the arm. We do not think the union is as strong as it should be and are holding under advisement drilling of holes through the under surface of the ends of the fracture in an effort to excite the formation of callus.

Case 3. Initials S. O. Male, age 18. 1/14/19. Fell fifteen feet from scaffold. A piece of iron weighing 150 lbs. fell, striking him on left shoulder.

X-ray showed fracture through anatomical neck of humerus and head of humerus. Plaster paris dressing applied. Position not good and on the 1/24/19, incision over shoulder and metal screw inserted in such an angle as to bring fragments together.

3/6/19. Union, plate and screw removed. Has now perfect function of shoulder and arms.

Case 4. B. G. Male, age 39. 4/14/19. Was thrown from wagon, sustaining a fracture of left tibia and fibula. Was taken to another hospital and five weeks later was transferred to the Crozer Hospital. X-ray showed complete fracture of tibia and fibula, three inches above malleoli. Fragments over-riding. No callus present. Fracture compound.

5/23/19. Incision over line of fracture and ends freshened. Bone inlay inserted into tibia. Ends of fibula freshened and approximated. Wound closed with insertion of small drain. Slight infection followed operation but soon cleared up.

Discharged 7/3/19, position good and lots of callus.

Case 5. J. M. Male, age 25. 7/15/19. Fell from scaffold, fracturing left femur. X-ray showed comminuted fracture of lower third of left femur.

7/19/19. Large incision over fracture. Removal of several loose fragments of bone, making considerable loss of bony structure. It was difficult to keep the fracture in apposition and on this account it seemed advisable to use the plates in place of the inlay so two plates were used, one anteriorly and

the other externally or laterally. This held the bone in very good alignment. Considerable infection followed but has since cleared up. The x-ray shows position very good and callus in abundance, surrounding the fracture.

In conclusion, we believe that it is better in certain types of fractures to cut down on the fracture as soon as practicable and use one of the many means at hand to hold the bones in the correct position and then apply external fixation.

The results in every way are so superior and satisfactory to the uncertain, frequently painful and cumbersome splints, that we owe it to our patients to give them the benefit of this I might say, "ideal technique."

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### **EMERGENCY SURGERY AS IT APPLIED TO THE REGIMENTAL MEDICAL OFFICER.**

BY

THOMAS L. DOYLE, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

NEVER before in the history of the medical profession has the adaptability and initiative requiring quick and fairly accurate diagnostic methods been brought to bear on the younger members of the profession than in the past world war. When I say younger members I am referring to all men capable, physically as well as intellectually of coping with the irregularities occurring in the life of the Regimental Medical Officer; and presupposing that similar circumstances in all armies as in the A. E. F. compelled the younger man to be sent into the line to act as the advisor as well as the comforter of a large body of men already hardened by the vicissitudes of war, and gathered together from all walks of life, makes one feel what an important factor that single individual seemed to be at a time using the expression "When a fellow needs a friend."

Realizing that each medical officer at all successive stages of the war was responsible as to the manner in which he handled the one thousand souls entrusted to his care, should any or even all of them become casualties, one readily can suppose what other preparations were necessary, to aspire to



his objective, when we realize that a portion of that dependence had to be placed on the shoulders of his stretcher bearers; who, previous to their assignment to the regimental officer, had a few days' instructions in first aid. Every track or route of evacuation was thoroughly travelled by him and his men and concentration points (familiarly known as bearer posts), had to be established, not in some secluded spot of the shell-torn field, but oftentimes within sight of the enemy, depending upon his humanitarian instinct to allow it to remain. Morale played an important factor for it was many times necessary for him to show his men that he would never order them to a lively corner without first going there himself.

In dealing with the daily life and part played by the Regimental Medical Officer, one always bears in mind the front line dictum, whether it be peace time, warfare or times of advance, "Get the wounded man to the casualty clearing station (field hospital) as soon as possible. Do all you can for him, either on the field, regimental aid post, or advanced dressing station, as quickly and thoroughly as time will permit so that there will be no need to disturb the patient again on his journey down."

Laboring as he was among hundreds of men it was utterly impossible to administer to each and every one. Let us then take, for example, the treatment of a single case.

HEAT, in bold, capital letters, stands out as the first recourse of the physician irrespective of the conditions concurrent at the time, and MORPHIA, which was generally required as the next salvation to the wounded, wherever he may be found, till time would permit his removal to a place of safety, or a spot where his injuries could be thoroughly dressed. Before the advent of the physician, the first field dressing carried by every man was usually put on by a stretcher bearer or one of his comrades, and consequently it had been soiled by contact with dirty or muddy hands, and had been applied to a dirty and unwashed skin. The same may have been applied very tightly with the intention of arresting hemorrhage, and for all these reasons it was his duty and of the utmost importance that the first field dressing should be removed as soon as possible. If time (a very important factor) permitted, the surrounding skin was cleansed and hemorrhage controlled by hemostatic forceps, pledgets of cotton placed into the wound, the use of tourniquets being contraindicated. Gross impurities

were removed from the surface of the wound, but no attempt was made to reach the deeper parts, to remove foreign bodies or to inject solution. For all purposes of cleaning, pledgets of wool and forceps were used, there being no necessity to touch the wound by hand. In all one's experiences and from reports of other men engaged in front line work *proper* splinting of large flesh wounds of the extremities as well as of fractures was of the greatest importance.

No operations were done by the Medical Officer in busy times, except those that could not be delayed, but completely shattered limbs were removed and all serious bleeding arrested before the patient was sent on. The use of a general anesthetic for the performance of such operations was resorted to very seldom as wounded men, even if time would permit a general anesthetic, travel badly and it was necessary to delay their evacuation some time until they had sufficiently recovered to stand the journey. A previous injection of one-half grain of morphia permitted the rapid division of the structures still attaching the mangled limb to the body and for local operations a 1 per cent. solution of novocain injected subcutaneously was used. The shock having been combated by heat infusion and stimulation of other forms while the wound was being dressed, the future success of the case in the after-measures employed, depended upon an accurate knowledge of previous history supplied to surgical teams in the field hospital.

Morphia having been given the letter *M* was put on the forehead with indelible pencil, and if time permitted the prophylactic dose of anti-tetanus serum (1500 units employed in Flanders; 750 units further south toward Saint Quentin); a blue *T* was likewise marked on his left wrist.

In times of stress, to prevent harm to the patient by persons over-zealous in tending to their wants during evacuation, we employed ribbons to designate the nature and severity of the case—be it abdominal, head or chest, or extremities.

*Red* signified abdominal, requiring immediate attention and that nothing at all should be given by mouth.

*Blue*, wound serious but liquids were permissible.

*White*, time could be spared and eatables could be given.

While all this information was absolutely essential there remained still the most important part to be played in army life, the "paper work." This was in the nature of the field medical card, containing the name, rank, regiment, age and

time of service of the patient, which was filled in by the Medical Officer who first dressed the patient, and it was of greatest importance to the wounded man that it should be done carefully. Here quick and accurate diagnostic methods were employed for it was not sufficient to make a diagnosis of gunshot wound of head, if the condition really were compound fracture of skull; also shell wound of the thigh, if conditions present were a fracture of femur, possibly compound in character. After diagnosis the amount of morphia and time of administration was recorded; record made of any operation performed, date of administration of A. T. S. and the case was ready to proceed either to the main dressing station or field hospital.

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### BATTLE SANITATION.

BY

CHARLES B. HOLLIS, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 18, 1919.)

THE matter of battle sanitation is one that seemingly flashes into the minds of all sanitarians from time to time, but I dare say that owing to the almost insurmountable obstacles in the path of efficient sanitation during battle, the average thinker is better satisfied not to consider the subject. But to some, this subject has been most real, and certain degrees of success in the handling of the situation have been attained. Each corps or division operated mostly upon its own initiative, and diverse solutions of the various problems were doubtless evolved. It is, therefore, my purpose, gentlemen, to recite to you briefly, some of the problems encountered in the situations occupied by the 82nd Division during the Meuse-Argonne offensive. To begin with, our greatest obstacle was the immediate collapse of the personal element in sanitation. Despite training, drill, lecture-work, and all of the other methods employed over a period of months, to impress upon each individual the significance of personal hygiene, camp, and field sanitation, and despite the degree of efficiency or proficiency attained in camps or training areas, I think that I express the opinion of all observers when I say that there was an almost complete collapse in that which we call the "personal element" in military sani-



tation. Anticipating this, from previous experiences in minor operations, it was sought to overcome this deficiency by supplying troops whose duty it was to correct sanitary offences only. The period to which I refer was from about October 6th to November 4th, 1918. The local situation was as follows: The 82nd Division was immediately behind the 28th Division, which was at that time in contact with the enemy, and making progress. The writer, as Division Sanitary Inspector of the 82nd Division, was in daily communication with the Sanitary Inspector of the latter division, or with the Corps Sanitary Inspector, and the methods later employed were the results of the compiled experiences of the three officers. An attempt had been made by the 28th Division to accomplish the field tasks with special troops, but despite the fact that in this operation each division had a comparatively small front in which to operate, it was found that the *one* company of troops of which they made use, was grossly inadequate, and as a consequence, the retiring division necessarily left behind them many dead and much refuse. The writer, therefore, made requisition for three such companies, and was fortunate enough to receive them, despite the fact that they were not full companies. They averaged about 160 men each. They were equipped with shovels, picks, litters, blocks and tackle, transportation, etc., and were assigned the following duties:

1. Seek for and locate all dead. Transport them to places suitable for burial, avoiding long hauls, but still providing that as many as possible should be placed in each grave. This was desirable as it made more certain the establishment of national cemeteries, and at the same time diminished greatly the amount of work to be accomplished by the Graves Registration Service which eventually followed up the troops, completing records and improving the general appearance of the small cemeteries. The method employed for the actual burial was as follows: Bodies were assembled at places suitable for burial, and instead of digging individual graves, trenches were made. It was not our practice, nor that of any other burial parties to my knowledge, to make use of any pre-existing trenches or openings. These trenches were usually about seven feet wide, four feet deep and two feet in length for each body to be interred. As many as 35 to 40 men were oftentimes placed shoulder to shoulder in a single trench. Before burial each body was searched for the necessary records, personal effects, etc., which were made

proper use of, then after an appropriate funeral service, which was an invariable rule for both allied and enemy troops, bodies were covered over with some sort of more or less impervious material, such as would tend to prevent the upward burrowing of maggots, and the graves subsequently filled in. Material for covering the bodies was always very plentiful about the battlefields. In the accomplishment of this task we were aided by the combatant troops who in many instances collected certain of their own dead under cover of darkness and so placed them that they could be removed in a motor truck to convenient burial sites. In this latter respect, may I remark for several days due to a scarcity of drivers, I personally drove a British motor truck which was assigned to me for this purpose and in places where no truck belonged, it having been the target for direct sniping by German light artillery. However, my presence here today is a paradoxical testimony to their marksmanship. There were, of course, details of record and the disposal of effects for which these troops were responsible, but which do not bear upon the subject of our present interest.

2. Locate and dispose of all dead animals within the division area. Fortunately this was in many instances a simple matter, for most dead animals were in the open or near roads, and were also very readily seen. The burial was also simplified by the ever present shell hole, into which an animal could in most instances be placed, after breaking the extremities. For purposes of removing dead animals a block and tackle was used, or a truck, or a team or whatever was available. When no shell hole of sufficient size was handy, graves were dug, the remains placed therein and properly covered, making sure that at least two or three feet of earth covered the whole.

3. The police of the camp sites, disguarding ration dumps, and the terrain in general. This consisted of the collection and placing along the roadsides of all waste material for salvage, including cans, boxes, government property, and materials left behind by the enemy, the turning over of the omnipresent "camp butterflies," and the correction of any other sanitary nuisances which presented themselves, including the burial of waste meats or food products and the burning of such rubbish as was of no value, provided the fires were not subject to criticism from a military viewpoint. To accomplish these ends the companies were assigned areas as follows: Two companies to the forward area, one with each infantry brigade, so to speak,

and one (the third) in the entire rear area, to care for the area left by the preceding division, and to follow up in the general advance thus making a second search over the terrain. These companies were further divided into teams, so to speak, under a commissioned officer or a non-commissioned officer, which officer carried a map of the terrain. On this map accurate record of each day's progress was kept, and in this way assurance was made that no territory was overlooked.

Further, the sanitary inspector and his assistants spent the greater part of their time covering the terrain and recording, also on large scale maps, the location of sanitary nuisances to be brought to the attention of team leaders. This general arrangement proved very satisfactory and it is felt by the writer that although when relief came to the division, a hasty withdrawal was made, and as a consequence no final and complete inspection of the terrain was possible, practically all of the dead up to the very forward area were buried, the general police of the entire area was very satisfactory and enormous quantities of the salvaged materials were assorted and stored at a division salvage dump operated by these same troops.

A second subject of paramount importance in battle sanitation, is the water supply; but as this subject is a lengthy one in itself, I will not go into it in detail here, but will merely remark that the chlorination treatment of water, so far as individual water detail was concerned, suffered a collapse, similar to that which was common to all other sanitary measures. And among combatant troops the ingestion of raw water was the rule. As a consequence, vast numbers of men were of necessity evacuated to the rear with exhaustive diarrhoeal conditions, the stools of infectious diarrhoeas were deposited at random, and our common enemy, the fly, had splendid opportunity to get in his work. My observations along this line convinced me that never until the water service is perfected to the point where pure or treated water in canteens is carried right to the fighting man, and there exchanged for his empty dirty canteen, will the army be able to control the rapid spread of intestinal diseases during combat.

The next subject of concern, from the viewpoint of the sanitarian is bathing. Naturally, to the troops actively engaged in battle, bathing is unthinkable, but considering that there are front line troops, support, and reserve troops, all of one division, and the supply train troops, etc., it can be seen



that bathing even during an advance can be accomplished for many troops. In this particular instance, the division acquired, during the 29 or 30 days of engagement, an elaborate bath and de-louser left by the enemy, which, on account of its location, was accessible to the troops not actually in combat. Also from corps two Foden thresh motor de-lousing lorries were acquired. One of these was set up at the combined field hospitals, where it was used, together with a French portable shower bath, to bathe all troops going through this unit.

Here, also, quantities of clothing, underclothing, etc., were kept on hand, and men were not only bathed, but re-equipped before being sent to the rear or returned to the front. The other such truck was set up in a town, convenient to the reserve troops, and this operated to capacity, and at the same time clean clothing was issued from this unit. Later on in the engagement, a quite large unit, housed in a substantial building, was acquired from the enemy, and despite the fact that its location rendered its use hazardous, it was at once put into service. Further, by the time the division was relieved, all four units were working to capacity, clean equipment was comparatively plentiful and as men were relieved, they were, with but few exceptions, bathed at one of these units, and either re-equipped or de-loused.

This, then, completes the rather abbreviated discourse on battle sanitation, having naturally overlooked many of the smaller details, and some of the larger ones, including food, water, shelter, sufficiency of clothing and equipment, sufficiency of medical stores and attention, etc., all of which come under the attention of the sanitary inspection.

In closing, let me emphasize: First, that in combat an absolute collapse of the expected results of sanitary training must be anticipated. Secondly, the importance of supplying an adequate number of troops to each combat division, whose duty it should be to bury the dead, salvage property, and police the terrain; and, thirdly, that the spread of water-borne intestinal diseases during active engagement, cannot be prevented by mere instructions to troops, no matter how thorough. But the details of the water supply should be as thorough as those of food supply, and a daily interchange of clean, full canteens be substituted for the dirty empty ones.

## EDITORIAL

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### SOME OLD AND NEW REMEDIES—II. CUPRUM ARSENICOSUM.

CUPRUM ARSENICOSUM is essentially a remedy belonging to the homœopathic school of medicine. It is true that it has been recommended as a remedy for anemia on the principle that arsenic and copper individually are helpful in such conditions. So far as we are concerned it does not appear to have had any provings worthy of the name, aside from a few experimental observations. Our early literature on the subject is limited to the single observation by Farrington, that it was helpful in cases of pure visceral neuralgia. The first extended use of the drug originated with Goodno who, by reason of deduction from the symptoms of copper and arsenic, brought it forth as a remedy in uremia, and we might say, nephritic states. In these it has become so popularized as to endanger its reputation. Naturally, being useful in a certain limited condition, the results are not likely to be good if the drug is prescribed indiscriminately. So far as we can discover there appears to be no settled symptomatology to distinguish it from its component medicines. Reviewing the article on cuprum and arsenic in Allen's *Materia Medica*, confirms the probability of this assertion. We note the reference to cuprum and arsenic as allied remedies. Furthermore, the general clinical indications for both remedies run almost parallel. There appears to be a notion more or less widespread among the profession, that cuprum arsenicum is a diuretic. We cannot understand how this idea ever gained general acceptance. Experiments made some years ago in the Hering laboratory proved its falsity. Like many other physicians we have used the remedy in renal diseases. Sometimes symptomatically, based upon our knowledge of arsenic and copper singly, and sometimes empirically; quite naturally we got results of all kinds without being able to analyze so as to be able to formulate definite indications. We have noted a certain amount of carelessness or thoughtlessness in the determination of the proper dose. The drug is unquestionably

a poison. The practice which we condemn is that of using the low trituration tablets 1x and 2x without thought for the quantity of the drug thus taken by the patient. For example, ten tablets of the 2x taken daily means that the patient gets one-tenth of a grain of arsenite of copper in the 24 hours. Such a dose could hardly be said to be homœopathic, and, therefore, unsuitable for obtaining the best results, even though prescribed more or less empirically.

Copper and arsenic have been known to produce symptoms suggestive of myelitis; hence a prescription of arsenite of copper is admissible in cases of this disease.

In facial tics, *cuprum arsenicosum* is found a most valuable remedy. Here it should be given in the form of tablets of the second decimal trituration, equivalent to one one-hundredth of a grain four times daily, which may be increased to as many as six tablets daily after a couple of weeks. Old school men have recommended cupric sulphate in the treatment of the tics, but we believe that the arsenical preparation is much more efficacious.

In catarrhal enteritis, *cuprum* is used largely on empirical grounds. The dose, however, should be small—one five-hundredths of a grain every one or two hours, representing the maximum. It is indicated by stools containing large quantities of mucus, cramp-like pains in the abdomen, and tenesmus recti and prostration. Many years ago the late Boardman Reed, of Atlantic City, popularized this use of the drug among old school physicians, advocating it especially as a remedy for the severe diarrheal affections of infancy. The same symptoms have led to our use of the drug in the treatment of intestinal complications of typhoid fever.

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#### PATHOLOGICAL ANATOMY.

In the *New York Medical Journal*, dated February 28, 1920, there appears an article by Reimann, which calls to our minds a fact well known but apparently not generally considered. The title of this article is, "Errors in Abdominal Diagnosis as Seen by the Pathologist." It justly bemoans the dearth of pathological anatomists; while it speaks for better co-operation between the clinician and pathologist. Reimann states that, "Ewing recently lamented when it became necessary



to equip a large number of laboratories in military hospitals, the supply of so-called clinical pathologists was fair enough, but very few expert pathological anatomists could be found."

In many of our hospitals the autopsy is a rarity. Because of this the histo-pathologist gets little chance to develop himself. Many are the men who can discuss the most intricate clinical laboratory tests with an astounding familiarity; but relatively few are they who can intelligently study and demonstrate tissue changes. One other reason for this is that the study of tissue seems to be *passe* and perhaps another reason is that tissue examination is more tedious and less lucrative than the general run of laboratory work. Then, too, since autopsies are few, the pathologist's experience with tissue is limited to the specimens removed by surgeons during operation. While these tissues are very important and their study not to be neglected, still in many instances the pathologist is unconsciously influenced by the surgeon, and ceases the study of such tissue when he has either negatively or affirmatively answered the surgeon's question, "Is it malignant or not?"

Great advances have been made in medicine during the last two or three decades; but much of our reliable information relative to diseases has been handed down to us by men who were little, if at all, familiar with the microscope and other laboratory measures. Of paramount importance in the study of disease is the history. Probably influenced by the saw, "History repeats itself," the physicians of other times made close observations of their cases and studied each one carefully in order that when the repetition came they could recognize it. It seems that today some depend too much upon aids which are not aids until everything is considered. A urinalysis, a blood count, or a Wassermann standing alone, in the majority of instances, means nothing. It is only when the history and other clinical findings are considered that these tests assume their proper importance.

Since the history of the world has been studied by geological formations which present themselves as stone dead facts, there seems to be a fair chance to study diseases by their end products. True, the geologists may be far from the truth in their calculations; so may we be as observers of the results of disease, but the fact remains that histopathology has furnished the foundation of much of our knowledge. J. G. W.

## GLEANINGS

## PEDIATRICS

Conducted by C. S. RAUE, M.D.

ORANGE JUICE AND CONSTIPATION.—Observations made by Gerstenberger and Champion (*Amer. Jour. Diseases of Children*, Aug. 1919) in a normal infant 10 months of age to ascertain the relative position as a cathartic or laxative of orange juice to an equal amount of a 10 per cent. sugar solution composed of 6.5 per cent. glucose and 3.5 per cent. sucrose show in one period no difference between the two solutions, and in the other period a relative laxative advantage of the sugar solution over the orange juice, or better, a relative constipating ability of orange juice as compared with the effect obtained with the 10 per cent. sugar solution. During the sugar solution period anywhere from 95.71 to 96.53 per cent. of the water output went by way of the kidneys, and from 4.29 to 3.47 per cent. went through the intestines, while in the case of the orange juice from 97.15 to 97.25 per cent. of the fluid output went by way of the kidneys, and from 2.85 to 2.74 per cent. by way of the intestines. In other words, orange juice, relatively speaking, has been less laxative than a 10 per cent. sugar solution when given in doses of 15 c. c., six times in 24 hours. This observation confirmed their practical experience that orange juice in the maximum amounts ordinarily used had more of a constipating than a laxative effect, and, therefore, should only be used as an antiscorbutic or as a diuretic, but not as a laxative, and especially not for children who are already constipated. These observations they claim point to the important role that diuresis may play in the production of constipation, and it may be possible that some of the cases of constipation in infants supposed to be due to an abnormally long retention of the feces in the gut and a consequent too complete absorption of water in the large intestine are primarily due to the presence of a factor that causes an abnormal increase in the excretion of water through the kidneys.—*Archives of Pediatrics*, March, 1920.

MATERNAL SEROTHERAPY IN HEMOPHILIA.—Chalier (*Revue de Médecine*, Oct., 1919) proclaims that serum from the mother's blood is the most effectual treatment known to date for congenital hemophilia. He applied it to a youth of 17 who from birth had been subject to hemophilia, and it was growing constantly worse. The mother's serum caused the son's blood to coagulate normally in the test tube, and he was given eleven intravenous injections of from 25 to 40 c.c. of the mother's serum in the course of eleven months. There was never any local or general reaction, and the young man's condition is now more favorable than at any time in his life. Chalier declares that this success encourages systematic infusion of maternal serum every tenth or fifteenth day, kept up for two years at least. In the present case the treatment was not as regular as he wished, owing to the distance from the home. The mother came to him to have the blood drawn, and the next day he took the serum to the patient for injection.—*Jour. Amer. Med. Asso.*, March 20, 1920.

PROGNOSIS IN OPERATED CASES OF HYPERTROPHIC STENOSIS OF THE PYLORUS.—Goldbloom and Spence after studying the results of 163 Rammstedt operations conclude that the operation per se is, perhaps, the least

important factor in the mortality. The condition of the baby at the time of operation is certainly the most important factor.

They sum up as follows:

"1. The duration of symptoms prior to operation is probably the most important single factor affecting the prognosis. When symptoms have lasted less than four weeks, the mortality is only one third as great as when they have lasted four weeks or longer.

"2. The mortality in artificially fed babies is more than three times that for the breast fed babies.

"3. In infants weighing 7 pounds or less, the mortality was three and one-half times as great as in those who weighed more than 7 pounds.

"4. The mortality increases in direct proportion to the amount of weight lost previous to the operation.

"5. The mortality for breast fed infants who had vomited less than four weeks and who had lost less than 20 per cent. of their best weight is almost nil. The fatalities which occur are due to accidents usually avoidable when the operation is done by a skillful surgeon."—*American Journal Diseases of Children*, April, 1920.

AN EARLY DIAGNOSTIC SIGN IN BASILAR MENINGITIS.—David Gingold has noted in almost every case of tuberculous meningitis observed by him in the past seven years a symptom which he believes to be an aid in making an early diagnosis of this disease. This symptom, which he calls a "reflex strabismus," is obtained by flexing the head on the chest. Upon so doing either a bilateral or a unilateral internal strabismus develops which lasts as long as the head is kept in the flexed position. In many cases the strabismus is accompanied by a retraction of the upper eye lids and in some cases a contraction of the pupils has been noted. In the late or paralytic stage flexion of the head fails to produce a strabismus. The author states that "reflex strabismus" may be elicited days before there is sufficient pressure to produce paralysis or other meningeal symptoms of basilar meningitis appear.—*Archives of Pediatrics*, January, 1920.

## MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

PULMONARY COMPLICATIONS OF PARATYPHOID FEVER.—Klein and Torrey report four cases of typhoid fever with pulmonary complications and in conclusion state: "There seems to be a definite pulmonary form of paratyphoid fever which may be easily mistaken for any of the acute respiratory infections. The pulmonary symptoms and findings often precede any intestinal manifestations. Of the pulmonary complications, bronchopneumonia is the most alarming. As it has been shown that the bacilli are found in the sputum, we must recognize that bronchial infection may result in the patient becoming a chronic carrier as well as being a means of spreading the infection in the wards of a hospital. It is of interest to note that the bacilli have also been isolated from the purulent discharges of a chronic purulent otitis media, caused by other infections previous to the paratyphoid disease and that they were found as late as sixty-five days after the beginning of the illness. The organisms were also isolated from the secretions of a pyorrhea alveolaris. In view of Minet's findings and his ascribing the paratyphoid bacillus as the etiological factor in his cases of chronic bronchitis, it is worth while to examine the sputum of certain types of our chronic pul-



monary invalids for this group of bacilli.—*American Journal of the Medical Sciences*, April, 1920.

THE MEDICAL TREATMENT OF AORTIC ANEURYSM.—McLaughlin emphasizes the interest and value of medical treatment in a condition which is generally regarded as helpless from the point of view of therapy. We must express ourselves as being in accord with his ideas. In his article, he goes quite considerably into details of treatment; at the same time we must say that mere details without a knowledge of general plans of diagnosis and drug action will avail the physician but little in the way of securing practical results. McLaughlin's idea is that aortic aneurysm should be treated on the general appearance advocated for the care of any other syphilitic disease. As evidence of the soundness of his position he describes three cases of aneurysm treated with a fair degree of success after periods varying from fourteen months to three years. He criticizes the altogether too common practice of using potassium iodide alone instead of resorting to arsphenamin and mercury as with other syphilitic disorders. The article is replete with common-sense, and will well repay perusal by those who have aortic aneurysm under observation.—*American Journal of the Medical Sciences*, April, 1920.

THE SIGNIFICANCE OF YELLOW SPINAL FLUID.—Nammack summarizes his subject as follows: "(1) Yellow spinal fluid occurs in a wide range of diseases of the spinal cord and meninges; (2) the complete syndrome of Froin is comparatively rare in its occurrence; (3) in acute or subacute conditions the presence of yellow fluid strongly suggests the probable diagnosis of tuberculous meningitis or poliomyelitis."—*American Journal of the Medical Sciences*, April, 1920.

THE OCCURRENCE OF GLYCOSURIA IN MUSHROOM-POISONING, WITH THE REPORT OF FIVE CASES IN WHICH A MILD NEPHRITIS AND A RENAL GLYCOSURIA WERE THE PERSISTENT AND PREDOMINATING FEATURES.—Alexander reports five cases of mushroom-poisoning with resulting renal glycosuria and mild nephritis as predominating features. Associated symptoms included nausea and pain in the epigastrium, vomiting, dizziness, blurred vision and confused sensorium. After the subsiding of these preliminary symptoms all patients felt fairly well for a few days. On the fourth day headache became intense and was associated with an unpleasant taste in the mouth and vomiting returned and prostration was pronounced. The interesting feature now manifested was heavy cloud of albumin 0.75%, with sugar 2.5%. Microscopically there were numerous fine and coarse granular casts. There was also a moderate trace of diacetic acid. Glycosuria was determined to be of renal origin as the patients responded to the following postulates which are necessary to justify same.

1. The glycosuria must be independent of the amount of carbohydrates ingested.

2. There must be no increase of sugar in the blood.

3. The development of a nephritis decreases the glycosuria.—*American Journal of the Medical Sciences*, April, 1920.

CASE OF SPONTANEOUS HEMO-PNEUMOTHORAX FOLLOWING ARTIFICIAL PNEUMOTHORAX.—Heise and Krause report the following case which occurred in the service of the Trudeau Sanatorium: A man, aged 21, entered the sanatorium on Sept. 21, 1914, with hemoptysis and pain in his chest his only symptoms and with signs so few and indefinite that diagnosis at first was only

tentative. He did well for several months but toward the end of the winter his condition became less favorable. By March he was continually febrile and was having more hemoptysis. Meanwhile his signs indicated a slight stationary process while the X-ray showed markedly progressing involvement. Signs remained equivocal until May 7 when they suddenly cropped out and showed consolidation below the 3rd. rib and 5th. v. s. on the left side. Between September and May frequent sputum examination had been uniformly negative; but on May 27 the fifty-sixth examination was positive for the first time. By this time the patient was gravely ill. On June 2 artificial pneumothorax was performed. The next day, after raising himself in bed the patient suddenly experienced a sharp stabbing pain in his left side and soon became extremely ill. Application disclosed blood in the thorax. The patient went into collapse and died fourteen hours after the rupture of his lung.

At autopsy it was found that the pneumothorax needle had not injured the patient's lung. On the anterior surface near the caudal tip was a tear of the pleura over a small cavity and close to a short and very thick adhesion. The entire left lung was involved with a caseating process that was cavitating at numerous places. The left thoracic cavity contained about two litres of clotted blood.—*Amer. Rev. Tuberc.* Vol. 111, No. 12.

## OPHTHALMOLOGY

Conducted by WM. M. HILLEGAS, M.D.

**TUBERCULIN IN DIAGNOSIS AND TREATMENT OF EYE DISEASES.**—Because there is tuberculosis somewhere in the body it does not follow that the eye condition is of the same origin. The demonstration of the tubercle bacillus is but rarely possible and the microscopic examination of excised diseased tissue is feasible only in some anterior affections. From a practical standpoint, the most important factors in making the diagnosis of a tuberculous affection of the eye are the clinical appearance of the eye and the tuberculin injections. Tuberculous affections are characterized by their chronic course, low inflammatory symptoms, and the appearance of small nodules (tubercles) in the affected tissues. The latter are of the greatest importance, their presence being almost positive proof of a tuberculous affection.

To confirm the diagnosis the resort is made to tuberculin. The Calmette reaction is mentioned only to be condemned; the von Pirquet test has its limitations and when positive gives no clew to the location of the tuberculous focus in the body.

The subcutaneous test is the most reliable. For this Torok gives  $\frac{1}{2}$  mgm., 1 mgm. and 3 mgm. in children, and 1 mgm., 3 mgm. and 5 mgm. in adults. A local or general reaction simply means a focus exists somewhere in the body. The focal reaction is the most important and is the one which indicates that the tuberculous focus is in the eye. In those cases in which a local and general reaction is observed, the diagnosis of tuberculosis cannot be positively established. In such cases in which all other causes can be excluded, it is justifiable to consider the eye condition as of probable tuberculous origin.

The following conclusions were reached:

We consider an eye condition tuberculous only when a positive focal reaction has been observed.

In cases where, for some reason or other, a positive focal reaction cannot be obtained, but the patient shows a positive general and local reaction, and every other possible cause for the eye condition is, with reasonable certainty, excluded, we consider the case of probable tuberculous origin.

For diagnostic and therapeutic purposes, tuberculin should always be used in fresh solution, not over two weeks old.

For diagnosis in eye conditions, only the subcutaneous injection is of value. It can be used in children as well as in adults with practically no danger.

Tuberculin is a valuable remedy in ophthalmic therapeutics provided it is used in very small doses, in positive tuberculous eye affections, i. e. in eye affections where a positive focal reaction was obtained. Used under these conditions, there is no danger involved.

The treatment should be started with a very small dose—1-10000 mgm., increasing it slowly to the maximum dose that the patient can tolerate, which in no case should exceed 1 mgm. During treatment all reactions should be avoided.

Duration of treatment should be long. Relapses being frequent in those cases where treatment has been discontinued after an apparent cure following treatment of less than eight months.—*Archives of Ophthalmology*, V. lviii, p. 242.

**LETHARGIC ENCEPHALITIS.**—At the 1919 meeting of the American Ophthalmological Society, Dr. Hiram Woods of Baltimore, reported six cases in which the diagnosis of this curious disease seemed justified. Of the six cases, lethargy was the first symptom in three. This was soon followed by ocular disturbances. Eye symptoms divide themselves into two classes: (1) Those without paralysis, but showing curious spasmodic movements of certain muscles when others were called into action. (2) More or less complete ocular palsies. These included ptosis, convergence, pupillary action, accommodation, a transient paralysis of the externus inferior recti, and in one case. The nuclei of the third nerves seem the point of most frequent attack. In but one case was there optic neuritis.

Recovery was slow; indeed, after two or three months some of the patients were not well. Apparently this disease is not well understood; and it is especially likely to come under the observation of the ophthalmologist.

In discussion Dr. A. J. Bedell of Albany, N. Y., said that "three more or less distinct types have been clinically noted in his cases. The mildest characterized by sudden diplopia often so transitory and slight that before all serologic tests were completed marked improvement or recovery had been reported. On examination, these showed a rapid nystagmus, usually lateral but the vertical not uncommon. There was a tendency to convergence, with sixth nerve paralysis, headache and the usual sense of insecurity.

"The next severer type had diplopia practically for all distances, the general discomfort such as headache and mental depression greater, the nystagmus more marked and usually accompanied by other nerve pareses such as the third, fourth, eighth, ninth, tenth and eleventh nerves. The duration is longer and in some of the cases the mental side was so great that the patients were unfit for work, and two of them were confined to institutions of detention.

"The severest type is illustrated by a case, first seen by me in a sleeping state, having given a history of progressive somnolence with diplopia. The sleepiness progresses and despite all treatment, the patient died. Autopsy revealed the findings considered characteristic in this disease.

"The clinical condition of lethargic encephalitis is more commonly recognized by the ophthalmologist."

Dr. G. E. de Schweinitz, Philadelphia, stated that he had the opportunity



of seeing a number of ocular complications in connection with so-called lethargic encephalitis. All had the lethargic and somnolent stages; but in all, the first ophthalmic symptom was diplopia. Mostly the only muscle affected was the external rectus. Then there were a few cases in which oculomotor palsy, with ptosis, was the ocular phenomenon. In all these cases, one of which was studied after the onset of the somnolent stage, there has been a marked impairment of accommodation.

The third group is a very severe one, in which there is practically complete ophthalmoplegia externa.—*Amer. Jour. of Ophth.*, Vol. 2.

**OPHTHALMIC MIGRAIN.**—Posey reported a series of cases under his observation, in which permanent quadrant and hemianopic lesions followed so-called migrainous attacks. He says there is ample evidence in literature to the effect that migraine may be the forerunner of organic brain disease, and that an area of softening of the brain may follow, which may manifest itself by a permanent paralysis, aphasia, or hemianopsia. While such lesions usually occur in individuals predisposed in consequence of diseases of the walls of the blood vessels, it would seem that in certain cases the vascular lesions may occur in young persons and even in some adults with healthy vessels.

Posey also gave notes of a case of recurrent oculomotor palsy, or ophthalmoplegic migraine, occurring in a girl of 13; the first attack, with implication of the eye muscles occurring when she was but 6 years of age.

The case of a physician which was observed fourteen years ago was also recalled. He presented almost complete ptosis of the right upper eyelid, and a paretic condition of the inferior oblique and internal rectus muscle of the same eye. His ocular symptoms coincided with spells of dimness of vision, associated with flashes of light upon the side affected and followed by headaches and nausea. These seizures apparently were typical attacks of migraine.—*Penna. Med. Journal*, Vol. 21.

**OPHTHALMIA NEONATORUM.**—Shastid, because of the imperfections and omissions in the various enactments for the prevention of blindness and, inasmuch as, to his knowledge, no scientific or legal committee, or even an official of any legal or medical association has taken any step or steps looking toward the securing of efficient and uniform legislation concerning ophthalmia neonatorum; has drafted a proposed form of law which is composite of the various existing laws.

It cannot here be given in full; however, some of the provisions are: That any inflammation of an infant's eye or eyes accompanied by an unnatural discharge at any time within two weeks after birth shall be known as ophthalmia neonatorum. That it shall be the duty of the individual in attendance to employ the Crede method. Should ophthalmia neonatorum develop it shall be the duty of the attendant to report the case to the proper health authorities; and the parents, or anyone standing in loco parentis to the infant, shall be informed of the danger to the eye and the necessity for skillful and continued treatment. That an accurate record of the report and its time of receipt shall be made by the local health department, and the original mailed to the State Board of Health. That the attendant must state on the birth report what prophylactic measures were taken. That every physician who shall treat a case of ophthalmia neonatorum shall, within 48 hours after his release of the case, report in detail the history of the case to the local or State Board of Health. The State Board of Health

shall furnish free of charge to proper persons suitable prophylactic agents. The remaining eight sections deal with the health board's duty.

All institutions concerned shall post in a conspicuous place a copy of this act.—*Amer. Journ. Ophth.*, Vol. 1.

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## UROLOGY

Conducted by LEON T. ASHCRAFT, M.D., F.A.C.F.

**CARCINOMA OF THE BLADDER.**—Lewis and Moore (*Urol. and Cutaneous Review*, Jan., 1920) cite and place on record five cases in which more or less success was obtained in controlling or eradicating cancer. They state that it is now generally believed that benign tumors are curable by means of fulguration; that malignant papillomata are amenable to treatment with fulguration and radium, but that a division of sentiment exists with regard to infiltrating carcinoma. All recognize the greater resistance and rebelliousness of the latter form of tumor; but that it is without the pale of curability or inappropriate for fulguration is yet to be proved. Certain of their cases were favorably influenced by radium and fulguration. They are under the impression that the use of radium and X-ray makes the growth more amenable to fulguration; and they are in the habit, in the infiltrating cases, of using these means first, and fulguration later, if there is pronounced tumefaction. The radium was applied by means of a hollow capsule welded on the end of a silver wire, the whole being covered by a black rubber cap. The tumor being definitely located with the cystoscope the radium is introduced in the applicator, turned and held close to the growth, where it remains for eight or ten hours. Meantime, as occasion requires, the patient urinates voluntarily alongside the catheter. A very valuable use both of X-ray and radium now well recognized is their application following the removal of carcinomatous growth by open operation. It is considered as offering material assistance in resisting the recurrence of the growth.

**PROSTATECTOMY, WITH PARTICULAR REFERENCE TO THE MANAGEMENT OF HEMORRHAGE.**—Reder (*Urologic and Cutaneous Review*, Jan., 1920) owing to the fact that the suprapubic route seems to be finding much favor among operators at the present day, focuses his consideration upon that surgical measure. After the enlarged prostate has been removed, and the patient is bleeding, this hemorrhage should be checked as promptly as possible because these patients are usually old and in poor health, and therefore have little resistance. Their greatest asset is their blood, and every drop lost means a corresponding disturbance in the balance of their life's valuation. To trust to the cessation of the bleeding after the patient's return to bed is hazardous. There should be no free bleeding from the prostatic wound at that time. In order to prevent this, the surgeon, immediately after the prostate has been delivered from the bladder, should reintroduce the forefinger of one hand into the bladder, and that of the other into the rectum, so as to force the curtain of vesical mucosa down into the cavity from which the prostate has been enucleated. By kneading the opposed surfaces together for several minutes, a certain amount of contraction of the cavity will be found to have taken place, and this often arrests the bleeding. The bladder, at the same time, should be irrigated with hot boric acid solution (110 F.). If, at the expiration of five minutes, these procedures have not checked the hemorrhage, one may resort to subcutaneous injections of some therapeutic preparation recommended as a coagulant. Much valuable time, however,

may be lost in this way. It is better at once to use one of the following three measures. Placing a catgut suture about the bleeding walls of the cavity, which is rarely done on account of the difficulty in carrying it out, caused by the usual lack of a good exposure; tamponade of the cavity with two strips of gauze, each 24 x 2 in., which are so inserted that they can be removed later without much disturbance to the bladder wound; and the insertion of a Hagner bag, or its modification by Pilcher, which Reder considers as by far the most satisfactory procedure. The most important points in the after treatment are to keep the patient as dry and as comfortable as possible. After the third day, the bowels should be opened with some dependable drug, and kept open thereafter.

GENERAL SURGERY IN RELATION TO UROLOGY.—Morfit (*Urol. and Cut. Rev.*, Jan., 1920) believes that in estimating a surgical risk, the renal function is the most important factor. It not alone determines the operative procedure but also the anesthetic to be employed with the greatest advantage. This may be investigated by the general surgeon, but in the case of renal abnormalities, the aid of the urologist is necessary to determine their extent. It is frequently not realized that an operating cystoscope is an imperative necessity in the surgical outfit of a well conducted hospital. The urological armamentarium frequently reduces a case from major to minor, from serious or grave to simple, from hospital to office, from danger to comparative safety. The author states that a thorough examination should be made before performing appendectomy, in order to learn whether there exists a stone or other pathology in the kidney, ureter or bladder, so as to preclude the necessity of performing a second operation. As many abdominal operations are necessarily exploratory, Morfit has made it a rule to have his incision large enough for intra-abdominal palpation. General surgery and urology are so intimately related that men practising one must be somewhat acquainted with the other specialty and its progress.

NOTES ON CHRONIC UREMIA.—Richter (*Urol. and Cut. Rev.*, Jan., 1920) states that since anuria from accidentally or experimentally ligating both ureters does not produce uremia, the cause of uremia cannot be found in retention of normal urine. He believes the cause to lie in the varying condition, the constitution of the sufferer, changed character of retained normal or abnormal products, or metabolic processes attacking the system. A large number of substances, organic and inorganic, normal and abnormal, have been accused of producing uremia; but whatever those retained substances may be, they are not necessarily in every case identical. It has been shown that normal urine is poisonous, but the poison itself has not been demonstrated. Ascoli and others believe that the diseased kidney generates poisons. Nowadays, one has a precious phrase to do away with all such considerations—toxins; but as we know nothing whatever about toxins, Richter thinks that we should be cautious about explaining facts on such a problematic substance and calming our diagnostic conscience with an empty phrase. We should be more watchful of clinical data. Any one or all of the symptoms commonly diagnosed as indicating chronic uremia may very well be due to other causes, and only a close observation of the case can establish the fact. It appears to the author that under the term chronic uremia is embraced a variety of diseases, among which the most important is primary arteriosclerosis. It is frequently complicated by chronic nephritis, and is a source of many gastrointestinal lesions.



ACUTE SYPHILIS OF THE KIDNEY; REPORT OF A CASE.—H. N. Cole (*Am. Jour. of Syphilis*, Jan., 1920) reports a case of this rare condition, in which all the requirements for a definite diagnosis of this condition mentioned by Fournier (proof of a recent luetic infection, the appearance of a nephritis with lues, a lack of other sources for the nephritis, the high albumin content of the urine, the rapid onset of the kidney disease, and the tendency to uremia) were present, except the last. Of the six cases reported by Hoffman, however, none showed symptoms of uremia. This patient also showed a positive Wassermann reaction and the effect of specific therapy. Owing to the fact that this patient had an acute gonorrhea, it was impossible to examine a catheterized specimen of his urine for the spirochetes. The most striking feature in this case, as in others, was the enormous amount of albumin in the urine, with not enough granular and hyaline casts to account for it. Syphilitic nephritis is often fatal. The author recommends lessening the protein intake, putting the patient on a milk diet, and using injections of mercury in small doses or mercury rubs. Arsphenamin in small doses, however, seems to be more beneficial and less detrimental than hydrargyrum. In the author's case, the patient became salivated after a week of mercury rubs, and the albumin content of the urine was steadily rising. The result of the small doses of arsphenamin that were then tried was instantaneous.

THE INTERPRETATION OF THE RESULTS OF THE WASSERMANN TEST.—Bolton (*Urol. and Cut. Rev.*, Jan., 1920) considers the Wassermann reaction the most constant and persistent of all the symptoms of syphilis, and that even a weakly positive reaction indicates the presence of the disease, despite the absence of clinical manifestations. The disappearance of symptoms with the exception of the positive Wassermann merely indicates that the disease is held in abeyance for a time, and not that it is cured. The disease can be considered as cured only when there have been three consecutive negative reactions to this test when performed with the most delicate and sensitive reagents, such as the cholesterinized antigen or the Noguchi method. If, after all clinical symptoms have been cleared up, the patient still shows a positive reaction, redoubled efforts should be made to remove the last trace of the syphilitic poison. If salvarsan or neosalvarsan have been given, they should be administered more intensively, or the treatment should be changed to mercury, iodide of potassium, Fowler's solution or some other one of the arsenical preparations. The author explains the failure of any particular line of treatment on the assumption that the spirochetes may become accustomed to a certain drug, so that they will not be affected by it. Even after the patient has been dismissed as cured, the Wassermann test should be made at intervals of a few months for a period of two years; and subsequently, once in a while for as long as the patient lives.

THE SYPHILITIC CLINIC AND ITS SCOPE.—W. J. Young (*Urol. and Cut. Rev.*, Jan., 1920) believes that those in charge of a modern syphilitic clinic should be capable of diagnosing and treating lues in all its various phases; that the apparatus and personnel should be such as to meet the requirements, which are so many and varied that it is impossible for one man to meet them successfully; that the work should be systematized so that as much of it as possible may be done routinely, thus leaving time for anything requiring special attention; that not only the physicians, but also the nurses and other attendants, should have the interests of the work at heart, if success is to

attend their efforts; and that the different departments must be arranged conveniently, and their heads be accessible to one another, in order to secure the best results. The heads of all departments of the syphilitic clinic should be versed in the control of the patients, so as to keep them interested to the point of regular attendance and treatment until a cure is obtained.

## DERMATOLOGY

Conducted by RALPH BERNSTEIN, M.D.

**LYMPHANGIOMA OF TONGUE.**—In the case reported by Howell—that of a six year old child—no family or personal history of disease could be found and the Wassermann reaction was negative. The boy had congenital nevus of the lower lip involving the mucous membrane of the gum. At times there was bleeding. The child was three years old before any swelling of the tongue was noticed. It appeared on the posterior aspect and grew forward slowly, finally becoming stationary. There was constant breaking down of the vesicles which became ulcerated. The condition was then painful and the child had to bolt his food. He ate most things and was particularly fond of salt, but did not care for and avoided sauces. At times there was such enlargement of the tongue—apparently without cause—that it protruded from the mouth. The condition was then very painful and naturally was a source of much anxiety to the patient as well as to his parents. There was excessive salivation and speech was impeded. The tonsils were hypertrophied, the submaxillary glands were quite enlarged, and the sublingual glands were palpable.—*Journ. Amer. Med. Assoc'n.*

**THE INCIDENCE OF SYPHILIS AS SHOWN BY THE BORDET-WASSERMANN TEST.**—During the year 1918 Day and McNitt subjected two thousand nine hundred and twenty-five patients to this test. The incidence of syphilis as shown by the reaction was found to be lowest among the well-to-do; about twice as high among the middle class, represented by the patients using the pay ward, and about three times as high among the lower social class or patients using the free wards. Among colored patients the incidence of syphilis was about six times that among private patients.

Of the patients which gave positive reactions only about 15 per cent. were free from clinical evidences of syphilis. The percentage of clinically positive syphilis is highest in the strongly positive group, being 61 per cent., and lowest in the plus 1 positive cholesterol cases, being 7.3 per cent.

Of 853 white males, 30 per cent. gave positive Wassermann reactions; of 924 females, 16 per cent. were positive. Among the colored patients, 48 per cent. of 200 males and 40 per cent. of 273 females gave positive reactions.

Among seven cases of diabetes giving positive reactions, only one did not give clinical evidence of syphilis. Of four cases of malaria giving positive Wassermann reactions it seems probable that two of the positive reactions were due to malarial infection and not to syphilis.—*Prac. Med. Ser.*, 1919.

**TOXIC ERYTHEMA.**—Diagnostic difficulties are not infrequently encountered in making a differential diagnosis between eruptions of bullous lesions in toxic erythemas and a genuine pemphigus.

Before administering drugs, especially iodine compounds, it is advisable to first ascertain whether the patient is suffering from renal or cardiac insuf-

iciency. Caution must be exercised in giving sedatives, particularly hypnotics, for the relief of severe itching frequently to be found in toxic erythemas. While the drugs will relieve the symptoms temporarily, when the drug is stopped the itching will not only recur but will usually be greatly intensified.

As the result of anaphylactic sensitization there is an increased susceptibility to certain foodstuffs and to albuminous substances which are produced within the intestinal tract.—*Journ. Cut. Dis.*

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## SURGERY

Conducted by J. D. ELLIOTT, M.D.

**BRACHIAL BIRTH PALSY: A PSEUDOPARALYSIS OF SHOULDER-JOINT ORIGIN.**—Thomas has made a very careful and thorough study of the literature of brachial birth palsy and disagrees with the universally accepted theory that this lesion is due to injury of the brachial plexus. He insists that the primary and essential cause in most cases is in the shoulder-joint and when that is removed early enough we do not have to be much concerned about the paralysis. His summing up follows: (1) Obstetrical or birth palsy represents only one phase of a much larger shoulder-joint problem. Almost if not all shoulder-joint injuries are associated with a brachial paralysis, palsy or weakness of varying degree or duration. Very rarely will an actual nerve rupture be associated with the paralysis. (2) The best evidence of the absence of such a nerve rupture is the almost uniform and gradual disappearance of the paralysis. This is easily proved in connection with the adult cases, and seems to be true of the obstetrical cases, in which the paralysis is of longer duration and more difficult to follow up. If the crippling of the limb persists into adult life it will probably be found in all cases that a posterior dislocation of the shoulder is associated, often with some moderate permanent disturbance in the elbow-joint. (3) In obstetrical paralysis soon after birth there is a profound and almost if not complete paralysis of the whole limb and not a paralysis limited to the small Duchenne-Erb group of muscles. The extensive paralysis is best explained by the inclusion of the branches of the brachial plexus in an axillary inflammation consequent upon a birth injury of the shoulder-joint. (4) The extravasation into the axilla of blood and synovial fluid causes an immediate inflammation and later cicatricial tissue, all of which is probably absorbed in time, thus accounting for the disappearance of the paralysis. Such a pathology has been well established by operative and postmortem findings in the obstetrical and adult cases. (5) The Duchenne-Erb localization of the paralysis by electrical reactions to the deltoid, biceps, brachialis anticus (Duchenne and Erb), infraspinatus (Duchenne) and supinators of the forearm (Erb) has been widely accepted but not corroborated. (6) In his first four cases Duchenne found posterior dislocation of the shoulder which he said had occurred at birth and was chiefly responsible for the paralysis. He thought, however, that some of the paralysis was due to injury of the brachial plexus. In four later cases he did not find dislocation of the shoulder in any and attributed the paralysis entirely to injury of the brachial plexus. Since then practically nothing has been said of a shoulder-joint origin, the dislocation passing unrecognized, and all cases being attributed to injury of the brachial plexus. Since 1911, when the shoulder-joint injury was offered as the primary cause, this theory has made rapid progress. (7) It is very likely that sufficient traction on the head at birth to rupture the brachial plexus has never been applied in a successful delivery.—*Amer. Journ. of the Med. Sciences*, February, 1920.



THE THERAPEUTIC USE OF CARBON DIOXIDE AFTER ANESTHESIA AND OPERATION.—Coburn describes some experiments with the use of carbon dioxide after operation upon patients in the New York Post-Graduate Hospital and the New Jersey Hospital for the Insane. In his work the cause of the reduction of blood alkali is not acidotic in origin, but is due to excessive breathing with the blowing off of the carbon dioxide of the blood, reinforced perhaps by diminished carbon dioxide formation in the tissues under anesthesia, which leaves the blood abnormally alkaline. In compensation, alkali passes out of the blood, partly perhaps into the urine, but chiefly presumably into the tissues. This is the acapnial process.

After a description of the apparatus he uses, the author observes that the inhalation of carbon dioxide, properly diluted with air, is a highly beneficial and, with care, a safe treatment after anesthesia and operation. The beneficial effects are: (a) an augmentation of breathing which rapidly ventilates the anesthetic out of the blood; (b) a powerful stimulant effect on the circulation, particularly on the venous return, and a rapid restoration of the arterial pressure, without subsequent relapse or unfavorable consequences; (c) marked decrease of postoperative nausea, vomiting and thirst, and (d) a possible restoration of intestinal tonus.—*Jour. A. M. A.*, March 20, 1920.

A STUDY OF THE ARTERIES SUPPLYING THE STOMACH AND DUODENUM AND THEIR RELATION TO ULCER.—Reeves has investigated 62 human stomachs and duodenums removed at necropsies from 1 to 4 hours after death in order to determine, if possible, whether there was any difference in character of the arteries in the stomach and duodenum, in the regions in which ulcers are prone to occur. At the operating tables practically all ulcers of the stomach are found along the lesser curvature, and 98 per cent. of the duodenal ulcers are within one and one-half inches of the pylorus. The greater number on the anterior wall within the first inch.

The author states that the investigation shows that the anatomic arrangements of the arteries along the lesser curvature of the stomach and throughout the first inch of the duodenum are such that the arteries are predisposed to thrombosis. The plexus of vessels in the submucosa on the lesser curvature is made up of much smaller and longer arteries without as free anastomoses as in other regions of the stomach. The resistance offered the blood stream is constantly greater and, as a result, the blood current is slower as it enters the small arteries of the mucosa. The submucous plexus of arteries in the first inch of the duodenum is made up of relatively few vessels in comparison with other parts of the duodenum. They are small and do not anastomose freely; they give off branches to the mucosa some of which simulate the gastric type of spiral artery. The rather limited blood supply and the gastric type of artery predispose to thrombosis. Since the vessels are more likely to be occluded by emboli, it is reasonable to suppose that they are an important factor in the production of ulcer by hematogenous infection.—*Surg., Gyn. and Obstet.*, April, 1920.

INTERPRETATION OF ROENTGEN-RAY FINDINGS IN THE DIAGNOSIS OF PEPTIC ULCER.—While one of the most important advances in the diagnosis of gastro-intestinal lesions has been the development and the application of roentgenographic methods in this field, McClure and Reynolds point out some of the difficulties in reaching correct conclusions by this method. They report misleading findings in several cases from the Peter Bent Brigham Hospital, which demonstrate that cases occur in which either the presence

of an ulcer is not diagnosed, or in which the presence or absence of an ulcer cannot be definitely determined except by exploratory incision. It is necessary to interpret roentgen-ray findings in relation to the data obtained by careful and thorough clinical studies. In certain cases roentgen-ray findings are more confusing than helpful in diagnosis.

It is obviously necessary for the internist to become familiar with roentgen-ray findings. But he can scarcely hope to become as adept as the expert roentgenographer, for roentgenology is specialized work requiring much knowledge, large experience and great skill on the part of the physician engaged in it. The best results are obtained by the proper co-operation of the clinician and roentgenographer. The proper co-operation consists: 1. On the part of the roentgenographer, in the accurate description of roentgen ray findings present, portrayal of the most probable conditions which they represent and the exclusion of artefacts. 2. On the part of the clinician, in the integration of roentgen-ray findings into symptomatology and diagnosis. —*Jour. of the A. M. A.*, March 13, 1920.

**THE USE OF BEEF-BONE SCREWS IN FRACTURES AND BONE TRANSPLANTATION.**—Henderson admits that from a purely theoretic standpoint, autogenous bone screws are better than beef-bone screws. But in actual practice the theory has so many objections, such as the difficulty in making the screws or pegs properly and the extra amount of bone used, that he believes that the beef-bone screws are preferable. The question of whether beef-bone is suitable for a graft is not considered, for all that is demanded of the screws is that they provide fixation of the autogenous graft to the fragments. They are usually completely absorbed within six months to a year. He describes the method of preparing the screws, their surgical uses and summarizes as follows: 1. Beef-bone screws are a great aid in securing firm fixation of the bone graft to the fragments in fractures, and of the graft to the spinous process in the operation for fixation of the spine. 2. They are well tolerated by the bone and are gradually but completely absorbed. 3. Bone screws have not the strength of metal and must not be expected to stand great stress. Careful provision must be made for postoperative fixation of the extremity. 4. Drills, taps and wrenches of the proper size are essential for the placing of beef-bone screws. 5. The bone graft as commonly used in the intramedullary and inlay methods is too small. Fracture of the graft rarely, if ever, occurs if the graft is large enough so that when the operation is completed there is from 20 to 25 per cent. more bone in the fracture area than there is normally.—*Jour. of the A. M. A.*, March 13, 1920.

**PLEURAL EFFUSION WITH INVERSION OF THE DIAPHRAGM PRODUCING AN ABDOMINAL TUMOR; TOGETHER WITH REMARKS ON ACUTE PULMONARY EDEMA FOLLOWING TAPPING.**—Riesman describes the findings in a patient with a large, tense, rounded mass, slightly uneven, somewhat tender and occupying nearly the entire upper, left half of the abdominal cavity. Examination of the chest showed distention and a diagnosis of an inverted diaphragm containing pleural fluid was made from the physical signs in the chest. This diagnosis was confirmed by the removal of a large quantity of fluid by tapping and the disappearance of the tumor simultaneously. The patient suddenly developed acute edema of the lungs about a half an hour after the tapping and the symptoms were so severe that dissolution seemed imminent. An injection of morphine and atropine did no good, but the good effect of the application of dry cups over the back was remarkable.

The author points out that it is evident that a tumor formed by a bag of pleural fluid projecting into the abdomen must be considered in the differential diagnosis of abdominal masses. If the chest condition is overlooked, or when not overlooked, if the pleural effusion and the abdominal tumor are not correlated, the possible diagnostic errors are many. The tumor has a peculiar bulky feel, is tender to touch, does not move with respiration, has the shape neither of the spleen nor of the kidney and appears to have a deep attachment. Its true nature is revealed after aspiration of the chest, when it will be found to disappear. In the absence of tapping a roentgenologic examination is probably the best means of diagnosing the true nature of the tumor. Such an examination will likewise show whether after tapping the diaphragm has returned to its normal position and is functioning properly.

Acute pulmonary edema following tapping is very alarming and sometimes fatal. Usually a hypodermic of morphine and atropine will bring relief, but, as in the case cited, it may fail. The remarkable results produced by dry cupping must be due to some reflex nervous influence. Dry cupping is a good therapeutic measure in all forms of acute pulmonary edema whether due to tapping or other causes.—*Am. Jour. of the Med. Sciences*, March, 1920.

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#### PATHOLOGY

Conducted by JNO. G. WURTZ, M. D.

APPEARANCE OF ISOAGGLUTININS IN INFANTS AND CHILDREN.—Happ (*Jour. Exper. Med.*, March, 1920, p 313) tested the bloods of 131 infants and children from birth to ten and a half years of age, as to their group agglutinins. The grouping he found, as present in adults, is rarely present in the blood from the umbilical cord. It is therefore unsafe to transfuse an infant from its mother without making the preliminary tests. At birth and during the first month of life isoagglutination is rarely present, but the group is usually established by the first year and is always present as in adults, by the second year. Since he found that the grouping is established in the corpuscles before it is established in the serum, group I is the first and group IV the last to be formed; but the cell group is liable to change before the serum group is established. However, when the grouping has been formed in both the serum and corpuscles it does not change.

PNEUMOCOCCUS CULTURES IN WHOLE FRESH BLOOD.—Bull and Bartual (*Jour. Exper. Med.*, March, 1920, p 233) found by their work that the whole uncoagulated blood of immune animals is not so highly pneumococcal in vitro as generally believed. Blood of animals naturally immune to pneumococci delays the growth of these organisms as does the blood of animals artificially immunized. Phagocytosis seems to be the important factor in the destruction of pneumococci, because defibrinated blood, presenting fewer leucocytes than that not so treated, allows greater multiplication of the pneumococci.



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## SPINAL INJURY.

BY

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WHEN Mark Twain was shown an Egyptian mummy, and was assured that it was more than three thousand years old, he very indignantly told the guide that if he had any nice fresh corpses he "could trot them out," but he must not think that he could palm off any stale corpses on him just because he was a stranger. You possibly may harbor the same criticism when you learn the antiquity of some of the cases which I shall detail, but experience has taught that conclusions cannot safely be drawn from neurological cases until some years have elapsed, or death has closed the chapter.

By way of introduction, and at the risk of seeming impertinent, I shall briefly review the topographical anatomy of the spinal column and the cord, since a visualization of these structures is vitally necessary for the proper appreciation of the lesson to be drawn from the cases which I shall bring to your notice.

SPINAL ANATOMY AND TOPOGRAPHY.—The spinal column consists of 26 segments, so interlocked that very great force is needed to displace them. In the first place, the segments are united one to another by an intervertebral cartilage, said to be capable of resisting a strain of 7 tons. This is thinnest between the 2nd and 3rd C., the weakest part of the spinal column.

The vertebrae are united more thoroughly into a column

by the interlocking of articular processes on the pedicles. These processes are not only apposed, but the permanency of the contact is assured by a strong capsular ligament. Next, a broad ligamentous band is applied to the posterior aspect of the vertebral bodies from the foramen magnum to the coccyx—*anterior common ligament*. A similar ligament is applied to the internal surface of the posterior portion of the vertebrae, *i. e.*, the internal surface of the vertebral spines—*posterior common ligament*. The laminae are united with each other by a rather thin ligamentous webbing—*ligamentum flava*. The under and upper surfaces of each two contiguous spines are bound together by interspinous ligaments until the cervical region is attained, where the ligamentous tissue is replaced by muscle. Lastly, there is the *supra-spinous ligament*, which is a strong cord, attaching to one another the tips of the spines of the vertebrae from the coccyx to the 7th cervical, where it fuses with the *ligamentum nuchae*, which finally fans out, to become attached to the occipital ridge.

This arrangement assures great flexibility to the column as a whole, and yet renders it capable of retaining its form, and preserving its contents, except against great force directly applied, or extreme strains of flexion. The spine is also protected by very massive muscular structures, and we may also recall that the spines are approximately an inch in length, and that they may be extensively injured without damage to the other parts of the vertebrae, or to the contents of the spinal canal. I think that one anatomical fact is of interest in this connection: A patient was in my office the other day, who was apparently a physical model, an army officer, 31 years of age, 6 feet in height, well muscled, and well nourished, and yet when I tested him for ankle-clonus the ankle joint cracked like a pistol, and he told me that he was incapacitated for football, because his articulation at the ankle was so loose that in running his foot would sometimes bend over until flat upon its external aspect on the ground, showing that the tonicity of the ligaments is not always free from abnormality, and this fact may explain some cases of subluxation which seem unwarranted by any ascertainable etiology. This should be kept in mind in the discussion of the second case to which I shall refer.

The vertebrae have a central aperture, so that by their union is formed a bony canal,  $\frac{1}{2}$  inch in antero-posterior di-

mension, and  $\frac{3}{4}$  inch laterally. In this canal hangs the spinal cord, which weighs about an ounce, is about 16 or 18 inches in length, and  $\frac{3}{8}$  inch in diameter. It terminates at the 3rd lumbar vertebra in the infant, at the 2nd lumbar in an adult, and is actually and relatively shorter in the female. Remember in topographical diagnosis that practically the cord terminates at the lower margin of the scapula. It is suspended in a spinal canal and is anchored to the coccyx by the filum terminale. The cord is protected from lateral oscillation by the ligamentum denticulatum, which is a ligamentous band developed from the pia mater covering the cord. This ligament has a border with long shallow notches, and sharp projections, about 20 in number, which are attached to the lateral aspect of the dura between the points of emergence of the spinal nerves. I mention this for the especial reason that thereby a partial division of the spinal space is made vertically into an anterior and a posterior chamber. The arachnoid is a loose cellular structure, which may approximate quite closely to the dura. This tends to subdivide the sub-dural space, so that hemorrhages are quite local in their dynamic influence upon the spinal cord.

Compression of the spinal cord may be produced by new-growths in the canal, but generally speaking it is the result of fracture of the spine, or fracture-dislocation of the same, or growths or collections of pus, or hemorrhages, either inside or outside the spinal dural membrane, but the initial symptoms of hemorrhages within the cord itself are superficially so similar that I have included such cases, although they are destructive as well as compressive.

The spinal canal is divided into three possible areas of hemorrhage:

1. External to the dura is the epidural space, which is quite extensive, and is occupied by fat, areolar tissue, and a plexus of veins. This area is rarely the site of primary hemorrhage, but often of hemorrhages and collections of pus secondary to diseases of the vertebrae, which in turn, are almost always tuberculous or carcinomatous. Occasionally it will be invaded by aneurysm.

2. The second area of hemorrhage is in the sub-dural space; *i. e.*, between the dura and the pia. Hemorrhage is most common in this area; it is the result of fracture-dislocation of the spine, sudden overstrain of the mobility of the spinal vertebrae, possibly entailing a sudden elongation of



the cord, and is also one of the sites of hemorrhage from a general vascular deterioration from phlebitis, syphilis, or arterio-sclerosis.

3. The third area is in the substance of the cord intramedullary, and may possibly be the result of external violence, but is usually from vascular deterioration as in subdural cases.

Closely simulating hemorrhage, and almost indistinguishable in its results, is thrombosis or embolism of the vessels of the spinal cord, which is a common cause of organic spinal cord symptoms, during or succeeding acute infections or chronic diseases.

Invasion symptoms vary about thus: Fracture-dislocations give rise to immediate paralytic symptoms. Subluxation is usually acute in time, while epidural invasions are slow, and there is a gradual evolution of symptoms. All three conditions produce compression symptoms, and give rise to stiffness, weakness, and increased deep reflexes, often without sensory changes, and finally eventuate in spastic paraplegia. Next: Except in epidural cases, the immediate symptom is a sensation of a blow, or acute pain, or shock in the spine. If the hemorrhage is small or very slow, we may find only symptoms of a reactive meningitis, and a localized radiculitis. Radiculitis means clinically an irritation of the roots of the nerves in the affected area, either in continuity from the meningitis, or from compression, and the symptoms are in the main irritative, *i. e.*, as a result of this irritation the muscles innervated by these spinal roots will be prone to spasm, and perhaps there will be a constant spastic contraction (the amount of spasm is a gauge of the degree of irritation) not much wasting, and little or no change in sensation.

Intramedullary hemorrhage (hemorrhage within the cord substance) produces a sudden weakness, often has the shock symptom, like the other localization, but while immediately there is paralysis of the muscles innervated from that center, there is spasticity below the paralytic area, with wasting in the paralyzed area, and burning pains here and there, depending upon the completeness of the transverse lesion. If sensory tracts are only infringed upon, there will be an appreciation of burning in the whole area below the level of innervation of the lesion. If the cord is completely involved in the softening, there will be loss of voluntary motion, wasting and anes-

thesia, to all qualities, below the lesion, sweating and coldness, and at the upper margin of the area of paralysis there will be a band of burning pain, and of exquisite sensitiveness to touch (transverse myelitis). Thrombosis and embolism are sub-acute or chronic in evolution of similar symptoms.

This paper is actually a description of compression myelitis as I see it, emphasized upon the etiological side, and extended to include vascular lesions in the cord substance, since the invasion symptoms are at times confusingly similar to the foregoing condition.

The first case is one of fracture-dislocation.

CASE I.—A woman, 35 years of age, fell through a fire-escape, striking across a stone balustrade, and fracturing the 10-12 dorsal so severely that the spine of the 12th dorsal was turned vertically, and impacted in the laminae of the 11th and 10th. She was in shock, and completely paraplegic. She was operated in a half hour; the cord was found to be bruised and compressed; but the woman made a complete clinical recovery, and walked out of the hospital in 3 to 4 months. The cord was not compressed enough to physically sever it, nor long enough to set up necrosis. She had the typical paralysis, weakness, rigidity, exaggeration of deep reflexes, and sensory disturbance of a transverse myelitis, but in this case they represented paralysis of function instead of organic destruction. It may be of interest here to note that Hartwell, of Colorado Springs, points out that compression-fractures are most apt to be caused by hyperflexion of the spine, and process-fractures by a direct violence. He also says, when patients who have suffered from accident to the back, and who subsequently complain of pain in that region are carefully and completely examined, the diagnosis of fracture of the spine will not be uncommon; that a diagnosis of sprain of the back and lumbago and rupture of the interspinal ligaments will be less frequent, just as nervous dyspepsia in these days of Roentgenology is rather uncommon, while ulcer of the stomach and duodenum, chronic appendicitis, and disease of the gall-bladder have become correspondingly frequent. The question of operation for fracture-dislocations of the spine has been the subject of much debate in the past. I have seen a large number of these cases, and except in two or three cases results have not been good. That would not make such a bad percentage, however, when the gravity of the injury is considered.

It is probable that fracture-dislocations producing severe compression of the spinal cord cannot be relieved by any operation which is delayed more than an hour and a half. This case should be evidence for the affirmative of this proposition. The general position to be taken is that extension, and not operation, should be the rule in these accidents. In no event should *late* operations be done with hope of a restitution of function.

CASE II.—This is an instance of the compression of the cord from a subluxation of the vertebrae. C. W., a patient of Dr. W. G. Mead, had been riding on a bicycle one day in July, 1910. After the trip, in which nothing unusual had occurred, he felt tired in his left arm. In June of this same year he had also received a blow on the back of the neck at about the 2nd cervical, and was troubled by occipital headache (so described) up to the inception of the present illness. Shortly after this ride he began initially to lose power in his legs, and soon developed a motor palsy with rigidity of the whole body below the neck. On the occasion of my first visit, September 18, 1910, he was found to be a spastic quadriplegic, with extreme emaciation of the whole body and limbs, the trunk and limbs suffused with cold sweat, anesthetic and analgesic, and with incontinence of urine. The deep reflexes were exaggerated, ankle clonus, and Babinski's reflex were present. This rate of onset, and method of evolution of the symptoms indicated that by some force the spinal cord was so compressed, that voluntary control was lost below the point of compression, and that sensory information from the affected parts was cut off from access to the brain. By this time both hands had become so atrophic as to display the "Ape-hand." An X-ray exposure by Dr. Bunn showed the existence of a subluxation of the axis and the atlas, and a jury-mast was advised. This was applied by Dr. Bunn, and queerly enough, the long-standing headache (so-called) promptly disappeared. By November 6, 1910, he could make conjoined movements of the legs, although both were spastic, and on this day he was able to raise the right hand on to a table. On January 29, 1911, he was able from the prone position to assume the erect position by the use of the erector spinae muscles alone. On May 31, 1911, he was in full possession of his muscular and urinary control, and for the purpose of examination he had to be called into the house from the back-yard, where he, un-



assisted, was engaged in the construction of a screen-door. He had worn the jury-mast for eight months. On June 20, 1911, his plantar reflex was normal. Achilles normal, slight ankle-clonus, knee-jerks were lively (left greater than right). The cremasteric was slight but equal, radial and ulnar lively, with the left greater than right. Triceps and biceps easily excitable, but equal, with the left thenar greater than the right. Thenar atrophy pronounced in the right, but practically absent in the left (possibly an error in the record). Musculature normal. Temperature of the surface normal; no inco-ordination in the lower limbs, and only a suggestion of it in arms by finger-finger test. Sensory appreciation normal. These findings indicate that aside from a slight atrophy of the right (?) hand, functional recovery was complete. The dislocation evidently exerted its influence especially on the left half of the cord. At the present time the boy is employed in the merchant marine. Apropos of milder grades of such injury, Elsberg reports that trauma to the spine may set up such reactive changes in the dura that it will produce compression of the cord. Cicatrices in the dura, especially about the cauda equina, may similarly cause severe root-pains.

CASE III.—This arose from epidural damage. C. K., a girl of 14, began in November, 1909, to feel a growing weakness in her legs; a fear that her knees would give way under her. A peculiar sensation also developed about her abdomen (girdle sensation). She finally arrived at a condition which she described by saying that her "legs got all tangled up." After considerable dispensary experience, she was sent in February, 1910, to a hospital, where she remained under observation for six weeks, with a history of steady deterioration, and left with a diagnosis on the hospital records of either medullary tumor or transverse myelitis. After some treatment by physicians at her home, she arrived at the Flower Hospital, where I examined her on December 2, 1910. At that time she had total paralysis, both motor and sensory, below the nipple line, with an increase of all the deep reflexes, and general emaciation, was incontinent, and had two bed-sores on the sacral region. There was, of course, no pain, nor was there a history of any pain. Examination of the blood, urine, and spinal fluid, gave no information beyond a moderate leucocytosis. Examination of the spine showed an increased mobility in the dorso-lumbar region (unfortu-

nately the skiagrams have disappeared), but there was no distortion of the column. The only possible etiological information was the history of an acute cold while menstruating, about coincident with the discovery of the initial weakness. There was no history of family tuberculosis. In view of the apparent spondylitis, with the very moderate leucocytosis, and of the great probability that there was a compression myelitis, the diagnosis of a tuberculous epidural exudate seemed most probable, and, therefore, she was put in extension, and was given frequent and considerable doses of *Calcarea carb.* 6x. She made a slow but steady improvement, and was gradually exercised, so that on leaving the hospital on February 26, 1911, she was able, with assistance, to walk up the four flights of stairs to her apartment.

She at once took up her work in the household, still in extension by a plaster and then a fibre corset, which was not put aside until a year later. This was done against my orders, but in obedience to the more imperative dictates of fashion.

In October, 1915, she took a position as a general book-keeper, and since then she has lived a normal and active life up to the present time, with this exception: After having been at work about a month, she began to lose flesh, developed fever, night-sweats, a cough, and ready exhaustion. Rest, milk, diet, and *Calcarea* were prescribed, and in about two months she improved, gained weight, and by June she was robust, and has never since been the subject of concern. I examined her this week, and the only remaining sign of injury to her spinal cord is a suggestion of a Babinski, and some exaggeration of the knee-jerks, but she can retroflex her spine between the second and third lumbar vertebrae to nearly a right angle. It should be appreciated that the damage to the vertebrae and the compression of the cord were at different levels.

Hemorrhage in the spinal canal, sometimes termed spinal apoplexy, may vary so very widely in its amount, and, therefore, in the symptomatology of onset and final development, that I shall ask your indulgence for detailing two cases instead of the one example to which I have thus far limited myself:

CASE IV.—Mr. D., an artist, whose habits up to ten years ago might with considerable charity be phrased as irregular, was walking on the sidewalk of a New York street. He was abruptly seized with a pain in his dorsal region, which was so

acute that he got home with difficulty. This steadily increased until it had to be controlled by opiates. It extended about the abdomen, and down also into the left groin, and into the penis, and urination was difficult and frequent, but with no admixture of blood. The abdomen was rigid, and after a day or so, the same condition obtained in his right leg. A skiagraph was made, as stone was diagnosed in the pelvis of the right kidney. An operation was performed, and nothing was revealed as the cause of the pain. At this time a consulting surgeon was called in, and he confirmed the propriety of the operation, but after two examinations declined to make a diagnosis. It was noted at this time that at the slightest touch on the abdominal parietes the muscles would be thrown into a painful recurrent spasm, and it was suggested that the diaphragm might be involved. I saw the case at this point, and aside from the abdominal hyperesthesia, there was discovered nothing beyond an exaltation of the deep reflexes, and a poorly developed Babinski of the left foot. There was no paralysis, and aside from the abdominal hyperesthesia, and the distress from the abdominal spasm, there was no pain. The diagnosis was that a small hemorrhage had occurred in the canal (subdural) which had irritated the emerging combined sensory and motor nerve-roots (radiculitis), and for which time would probably be the remedy. I saw the patient again in a week. The operative wound had healed promptly, the spasm had disappeared in three or four days, and the slight Babinski was the sole residuum, and the only incident physically was the history of a transient girdle-pain about the left leg about three days after my first visit. The mental state of the patient was, however, very unfavorable. From the very inception of the trouble he had been very unreasonable, and seemed more excited than the amount of pain would warrant; on one or two occasions having to be restrained from attempts upon his life. At this visit he was disoriented and wandering, alternating with periods of absolute apathy. This condition persisted for about ten days, when he died. Autopsy showed that the suspected stone was a hemorrhage in the substance of the kidney, and the manner of his later illness and death suggested multiple capillary hemorrhages in the brain, although a complete autopsy was refused.

CASE V.—The second instance of this lesion was Miss T., 55 years of age, a patient of Dr. Bryan, who had for



many years been in feeble health, but without obvious disease. Her health had been better than usual during the fall of 1901, when, complaining of some headaches, it was brought to her notice that osteopathy had wonderful powers in turning back the clock of time, and like a provident person she made haste to embrace the opportunity to bask again in the sunshine of youth. She basked eight times with the result that she developed pains in her lumbar region, motor paralysis, and a feeling in her legs "like corns," with tingling. After a short interval for recuperation, she started again upon the process of rejuvenation, and had two more treatments, and then she had to settle down in her room to pass her new-found youth, as her legs would no longer carry her to the fountain of Ponce de Leon. Examination at this time revealed that initially she had a definite sensation of irritation in the rectum, a numbness in the whole genital area, painful spots and streaks all over her legs, so that it hurt her even to lie down in bed. Drop-foot soon appeared, and motor weakness in the legs with some atrophy below the knees. The upper extremities, appetite and sleep were normal; there was no rise in temperature, and the mind was clear. By June of 1902 she had become a chronic sufferer from recurrent painful spasms in the abdominal muscles, especially evident in the night and early morning, the paresthesias were still present, but the sphincters were still competent, and there were no bedsores. By December, 1902, while there was no actual paralysis of the legs they were weaker, spasmodic contraction was a frequent and persistent symptom, and the contracture of the adductors had become so pronounced that the legs had to be separated by force when the patient wished to urinate. While there were no bedsores, the hyperesthesias had become still more intense, extending from the scapulae to the toes, sparing the anterior surface of the trunk, and being especially severe in the toes. This hyperesthesia induced a spasmodic contraction of the rectal sphincter, producing obstipation. The lower limbs were only moderately wasted, but were moved with great difficulty, and the patient was now removed to an institution for incurables.

During 1903 she had spasms in the muscles of the legs, accompanied by so much pain in the sciatic nerve that she cried out, and the thighs were drawn up to the trunk. The adductors and flexors of the legs were constantly in a state of spasm, and by this time she had developed urinary and fecal

incontinence. The patient slept well in the absence of spasm, and could drag herself along by the support of a chair, but never walked.

During March, 1904, she unexpectedly showed signs of improvement. The hyperesthesia had disappeared from the back, except over the area involved in the removal of the coccyx, she had regained control of the bladder and rectum, but the feet were still painful, and the skin of the lower extremities was dark in color, and the skin was still dry and shiny. She soon became able to wiggle her toes, move her feet, sit up in bed, and cross her legs without assistance from her hands. The knee-jerks were thought to be slightly in evidence at times. There was no more spasmodic flexion of the thighs upon the abdomen, but she still suffered from contraction of the flexors, adductors, the lumbar muscles, and hyperesthesias on the backs of the legs.

On January 20, 1911, she was reported to be constitutionally well, but could not walk, and that her principal trouble was a constriction of the sphincter ani, which had been stretched twice during the month with benefit. The lower extremities were still contracted, and at times very strongly.

In March of this same year it was reported that during the last three months she had gained in strength and ability to move, and that the gain had been a rather steady one during the last two years. Appetite, digestion and sleep were very normal, muscular spasms not prominent, and the patient could lift her feet while sitting in bed. Movements of the limbs, however, soon fatigued her, and after a little exercise she developed nausea, vertigo, and pain in the head. It was said that she could sit up for two or three hours with comfort, except from pain at the end of her spine, and that the great toe no longer folded under, but "the next one humps up."

She had constant, often severe, pain in the rectum, relieved by heat, but the flexor spasm had not shown as continued improvement, as her legs often "drew up" at night, so that the heels almost touched the buttocks, this being especially true if she becomes chilled, and there was a dreadful sense of pulling on the abdomen and lower part of the spine. She often had to push on the knees, and hold them down with her hands; the right one did not quite straighten out, even with this pressure. This seems to be some degree of relapse, since last summer it was not so evident, and she went out in a rolling-chair.

On December 16, 1919, I learned that the patient still had considerable sphincter trouble, and intestinal inertia, requiring constant assistance in emptying the bowels, that she had many and distressing sensory symptoms, was not able to bear any weight on her legs, and at no time during her illness had been able to use crutches.

This case is an instructive one, in that it exhibits the combined effects of a moderate compression of the cord by hemorrhage, complicated by a reactive meningitis which interfered with the function of the emerging spinal nerves. It also shows that in time a very considerable improvement may take place under such conditions. Primarily the whole spinal meninges were in a state of irritation, but this affected area has finally become so circumscribed that only the lowest sacral nerves are compromised at present, but the compression of the cord was sufficiently severe and long-lasting to produce a permanent weakness of the lower limbs.

Vascular intramedullary injury has been stated to arise from either the occlusion of a vessel by thrombosis, or embolism, or by hemorrhage. Occlusion results from acute infections, or intoxications, or in chronic illnesses, and does not come within the scope of the present paper. Intramedullary hemorrhage is especially one of those acute conditions which naturally come to the general physician for primary diagnosis. I shall detail two such cases to illustrate the variation in etiology and symptomology:

CASE VI.—A gentleman was driving in his racing-wagon on the Speedway in New York. He felt a severe blow in his lumbo-dorsal region, and fell out of the wagon on to the road. To the bystanders, who at once ran up to him, he cried: "Who hit me in the back with that stone?" They knew of no stone, saw none thrown, but there was a general opinion that a passing horse must have thrown one with his hoof. He was taken to a hospital, and a physical examination showed no external signs of injury to the spine, but he was found to have a complete motor and sensory paralysis below the waist-line, and there was a strip of burning sensation around the body a little above the upper level of the paralysis. The abdominal muscles wasted very promptly. The deep reflexes of the lower limbs were exaggerated, and there was retention of urine. This was followed by a generalized atrophy of the lower limbs, and a paralysis with rigidity which became permanent.



In this case an artery ruptured from some cachexia, and the shock to the nuclei and tracts was so instantaneous and severe that it produced the sensation of a blow in the back. In these cases if a hemorrhage is of any considerable size, the consistency of the spinal cord is not firm enough to prevent symptoms which might suggest a myelitis; but if the hemorrhage be small, the symptoms may differ widely in character and distribution.

CASE VII.—Another instance of intramedullary hemorrhage which I saw is briefly touched upon, on account of its peculiarity of localization in the cord. A man fell from the platform of the Third Avenue Elevated Railway, dropping between the platform and the train, and by retaining his vertical position was rolled between the car and the platform until the train could be stopped, the injurious pressure being exerted upon the area between the pelvis and the lower border of the scapulae. He was instantly rendered paraplegic. The total paralysis lasted but a few months, when it was replaced by a spastic paraplegia, which permitted him to walk with the assistance of two canes. The functions of the bowels and bladder were reasonably well performed, but he had lost his perception of pain and temperature, while preserving his appreciation of touch. That is: He had that variety of syringomyelia which develops an associated spastic paraplegia. The reason for this peculiar result was that the hemorrhage took place not in the substance of the cord, but in the central canal, and the clot affected primarily the tracts or cell-groups which convey pain and temperature perception, and secondarily made pressure upon the motor tracts to the lower limbs.

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ENDOSCOPIC ELECTROCOAGULATION OF VESICAL PAPILLOMATA.—Nicolich (*Clin. Chir.*, 1919, XXVI, 609) relates the histories of thirteen cases that were treated by this method, devised by Beer, which has been employed by numerous surgeons abroad with excellent results. One advantage that it has is that it makes cystotomy unnecessary. That surgical procedure may bring about a recurrence, by inoculating the bladder wall with small particles of the tumor. A second advantage of the endoscopic method is that the patient need not stay in the hospital. After this treatment, a cystoscopic examination should be made at intervals, so as to find out whether a real cure has been obtained. In case of recurrence, one more treatment will usually bring about a cure. In all of his thirteen cases the author secured excellent results.

THE VITAMINE PROBLEM IN NUTRITION.<sup>1</sup>

BY

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WHEN and why is a sufficient diet inadequate? This is the problem to which we address ourselves. If experience tables show that 3,000 calories, including protein, fat and carbohydrate in proper proportions are truly sufficient for the average man at average work, and that 8,000 calories are truly sufficient for an active man at heavy work (for example, the Maine lumberman), how can these or other diets derived from experience be spoken of as insufficient or inadequate?

Diets in which proper balance among the food factors has not been maintained have come to be associated in experience with certain diseases. Unbalanced diet, it is said, may produce:

Acidosis, in one form, from too much fat;

Acne or eczema, from too much carbohydrates and fat;

Beri-beri, from a monotonous diet consisting chiefly of rice;

Constipation, from too nutritious and concentrated diet;

Gout, from various dietetic errors;

Pellagra, from a deficiency of protein, and from too monotonous a diet of maize;

Rickets and marasmus, from too much starch, and too little animal food and salts;

Scurvy, from too little fresh fruits and vegetables.<sup>2</sup>

It is by no means the intention of the speaker to assume the correctness of all these associations of disease with diet as the cause. They are merely quoted, and represent what may be read in books. Nor is it the intention to exclude other suggested causes. Bacteria and protozoa have been suggested<sup>3</sup> with reason as causative agents in some of these diseases. Poverty and crowded and unsanitary conditions have so often accompanied some of them as to be taken for their causes.<sup>4</sup> In

fact, it is by this avenue that the consideration of these diseases comes least mistakably into the field of students of hygiene, as one of whom I speak. For pellagra at least, auto-intoxication has had its advocates,<sup>5</sup> and the photodynamic theory its champions.<sup>6</sup> The question of the presence of active chemical poisons in the diets has been raised and discussed,<sup>7</sup> and the correlative question of the absence or lack of some essential principle in the diets has been brought to the foreground.<sup>8</sup> To this last mentioned idea, much attention is today being devoted.

The pioneer in the field of deficiency diseases, if we may speak of any as such, may have been Dr. Thomas Barlow. In 1883 he discussed<sup>9</sup> the peculiarities of no less than 31 cases of infantile scurvy,<sup>10</sup> since known as *Barlow's disease*. At a later time, 1894, he speaks<sup>11</sup> of "prolonged deprivation of fresh vegetables or their equivalent as the most constant fact among the antecedents of the disease—prolonged, because it is clear that the organism has the power of drawing on its reserves for lengthened periods to meet the deprivation of a complete aliment; the phrase fresh vegetable or their equivalent being used because we now know that fresh uncooked meat and fresh milk are antiscorbutic as well as, though perhaps not in so rapid a way as, fresh vegetables and fresh fruit juices. It seems fair to say that *the further we get from a living food the less is the antiscorbutic power*. Fresh vegetables are more powerful antiscorbutics than preserved or cooked vegetables. Raw meat is more antiscorbutic than cooked meat, and raw meat juice than beef tea. I suspect that it will ultimately be found that raw uncooked milk is more antiscorbutic than cooked milk." Barlow's observations were clear and found practical application of most importance. But they did not initiate or stimulate any considerable scientific inquiry.

The next advance in the study of deficiency diseases resulted from a spontaneous outbreak of sickness among some fowls in Eijkman's laboratory (in Java). The disease involved nervous breakdown followed by death, and Eijkman<sup>12</sup> was struck by its similarity to beri-beri,<sup>13</sup> in human beings. After extensive study, he traced its origin to the *food* of the fowls. He was thus led to inquire into the occurrence of beri-beri among the native prisoners in Java and Madura. He obtained data from over 200 prisons: He traced the disease to rice, which was being used in all the prisons. But it was



being used variously. First, the rice was sometimes only partially decorticated, the bran layer being retained either entirely, or to the extent of at least three-quarters; second, such rice was used mixed with "polished rice," *i. e.*, rice from which the bran layer had been removed either entirely or to the extent of at least three-fourths; third, polished rice alone was used. The number of prisoners was over a quarter of a million. The incidence of the beri-beri, according to the kind of rice used, was found to be as follows:

Unpolished rice . . . 1 case to every 10,000 prisoners.

Mixed rice . . . . . 1 " " " 416 "

Polished rice . . . . . 1 " " " 39 "

Eijkman produced polyneuritis in fowls (identical with beri-beri in men) by limiting their diet to polished rice, and he cured polyneuritis in fowls by feeding them the polishings from rice.

The prevention of beri-beri in the Philippine Islands by steps based upon these experiments on rice is "little short of marvelous."<sup>14</sup> And the Japanese navy,<sup>15</sup> where formerly beri-beri affected about one-fourth of the personnel, has practically freed itself of the disease.<sup>16</sup>

Rice polishings are a complex mixture, all the constituents of which may not be active; some one or more would naturally be assumed to effect the cure. Following some such reasoning, Fraser and Stanton in 1907<sup>17</sup> found that alcohol would extract the active agent from rice polishings, and that the alcohol extract would effect the cure of polyneuritis. They extended their studies to man, and working under such conditions as to exclude as causative factors *place infection*, *intercommunicability*, and *unhygienic surroundings*, they made clear that what Eijkman had found possible with fowls they could reproduce with men as the experimental animals. They took 300 Japanese laborers into a virgin jungle, where the laborers occupied new and sanitary quarters. After excluding beri-beri by the careful examination of each person, the laborers were divided into two parties of equal numbers. One half received polished rice as the staple diet, while the other received undermilled rice with the pericarp. In three months beri-beri appeared among those receiving polished rice. When a certain number of cases had been noted, polished rice was discontinued, and thereafter no cases occurred. No sign of the disease appeared among the laborers receiving undermilled rice. The

conditions were then reversed. Those hitherto on undermilled rice were given polished rice, and after a somewhat longer interval beri-beri broke out in this group also. This outbreak also ceased on discontinuing the issue of polished rice. Again no sign of the disease appeared among the control party receiving undermilled rice.<sup>18</sup>

The power of alcohol to remove from certain foods some essential component was again demonstrated, shortly afterward (1909), by Stepp.<sup>19</sup> Grown mice, while satisfactorily nourished by a bread made with milk, when fed with the same bread after it had been extracted with alcohol showed early failure followed by death. If the alcoholic extract was put back into the diet, the bread again became efficient for maintaining life and health. The active substance was shown not to be the fat in the bread, for extraction of the bread with ether or chloroform did not in the least affect its efficiency as a food. This active substance that can be extracted from rice polishings or from bread by alcohol occurs in several food stuffs and can be extracted from all of them by alcohol. It is curative and protective against polyneuritis. In 1910 Schumann<sup>20</sup> added yeast to the list of substances that contain this curative and protective principle.

In 1911, Funk<sup>21</sup> thought that he had isolated the active substance, as a crystalline organic base  $C_{11}H_{20}N_2O_7$ , and to this substance he gave the name "Vitamine." Unfortunately others have thus far been unable to confirm the existence of such a crystalline substance as Funk described. Passing from the case of beri-beri, where he had experimental evidence to support his theory, Funk (according to McCollum)<sup>22</sup> extended his theory upon "clinical observations" to include pellagra, rickets and scurvy. He classed all four as deficiency diseases, resulting from the absence of some *vitamine*. Funk's *vitamines* were analogous to the *catalysts* of the chemist in this important and characteristic respect, namely, that the effects were great and out of all proportion to the energy content or the weight of the added *vitamine*. Clearly, the *vitamine* of Funk was not a food in the ordinary sense of the word. It was a protective and curative substance of great potency.

Diets are complex, and problems in diet, like other problems of complex character, are easier to solve if first reduced to simplest terms. F. G. Hopkins<sup>23</sup> reduced the constituents of experimental feeding mixtures used by him (in 1906 to

1912), to purified substances in place of the usual impure substances. Food mixtures correctly compounded but made from *purified* protein, *purified* carbohydrate, *purified* fat, and *purified* inorganic salts, Hopkins found *incapable of producing growth* in experimental animals. But he learned that if such mixtures of purified constituents have milk added to them (to the extent of 4 per cent. of the total dry matter), the mixture becomes capable of producing growth and supporting normal life. "No animal," he states, "can live upon a mixture of *pure* protein, fat and carbohydrate—even when the necessary inorganic material is carefully supplied. The animal body is adjusted to live either upon plant tissues or upon the tissues of other animals and these contain countless substances other than the proteins, carbohydrates and fats." He, therefore, suggested the existence of "accessory food substances" in addition to those previously recognized. These *accessory food substances* were as yet clearly distinct from the protective and curative food substances or *vitamines*, of Funk.

Osborne and Mendel <sup>24</sup> next showed that all of the milk is not necessary in order that the accessory food substances may be thereby introduced into a diet. They found that the evaporated residue from milk from which the fat and protein had previously been removed as completely as possible, if added, up to 30 per cent., to a diet on which rats had remained stationary in weight, promoted rapid growth.

By 1913, McCollum and Davis <sup>25</sup> had secured growth in young rats fed upon a mixture of purified food stuffs when the mixture contained butter fat, but they could secure no growth when certain vegetable fats or body fats of animals were substituted for the butter fat. This made it appear that the only mystery in the diet was that associated with the fat. Although whole wheat contains all the essential food substances (protein, starch, sugar, fat and salts) so far as chemical analysis can demonstrate, they found that young rats limited to whole wheat failed to grow and soon died.

They accordingly reasoned that the faults in whole wheat might depend upon a *lack* of the unknown substance contained in butterfat, or upon the *quality* of some one of the well recognized constituents of diets as these constituents occur in whole wheat. In their experiments they then improved the quality of the whole wheat with respect to each dietary factor one at



a time, in order to find which factor, if any, was interfering with growth. The results were:

Wheat alone . . . . .	No growth, short life;
Wheat x purified protein. .	No growth, short life;
Wheat x a salt mixture* . .	Very little growth;
Wheat x butter fat . . . . .	No growth.

These results showed either that their hypothesis was wrong or that there must be more than a *single* dietary factor of poor quality in wheat.

To test this latter possibility, they carried out experiments in which wheat was simultaneously supplemented by *two* purified food additions. The results were:

	<i>Growth</i>	<i>Offspring</i>	<i>Life</i>
Wheat x protein x salt mixture	Good	Few or none	Short
Wheat x protein x butter fat . .	None		Short
Wheat x salt mixture x butter fat . . . . .	Fair	Few or none	Short

These experiments were highly suggestive that there were three dietary factors of poor quality in whole wheat. They, therefore, performed experiments in which wheat was supplemented by *three* purified foods, as follows:

Wheat x protein x salt mixture x butter fat, thus obtaining good growth, normal reproduction and normal length of life. One of the conclusions they drew from this was that whole wheat is too poor in some unidentified substance which butter fat contains, as well as being too poor in certain inorganic chemical elements (later shown to be calcium, sodium and chlorine), and as lacking in certain protein constituents.

They then tried feeding rats upon a mixture of *purified carbohydrate*, starch and milk sugar; *purified protein*, casein; *purified fat*, butter fat; and *purified salt mixture*, of the composition of the ash of milk. In these experiments they secured growth and well being.

In the light of Funk's paper (1911) and Hopkins's experiments (1912), McCollum and Davis determined to use polished rice in a series of experiments parallel to their own experiments already described in which they had used whole wheat. To their surprise, when they used polished rice x protein x salt mixture x butter fat they obtained no growth and further the animals developed polyneuritis. Now the only

\*The salt mixture used was the same as that found in milk.

difference between this diet and the purified mixture described in the preceding paragraph was in the absence of the milk sugar (20 per cent.) It was, therefore, determined to repeat the experiments on the purified mixture described in the preceding paragraph with the change that starch should be substituted for the milk sugar. This was done and it was found that no growth could be obtained when the *milk sugar* was omitted. Further experiments showed that when the milk sugar was sufficiently purified by recrystallization it lost its power to induce growth, while the mother liquor from the recrystallizations if evaporated gave a growth-inducing residue.

McCollum and Davis then showed with pigeons that polyneuritis induced by polished rice, could be cured by the substance in milk sugar; and also by the alcoholic extract of wheat germ. But although these substances cured polyneuritis, experiment showed beyond doubt that *unless butter fat is also included in the experimental diets*, the alcoholic extract of wheat germ or the alcoholic extracts of other foods were not sufficient to induce growth.

At this point, McCollum and Davis formulated their working hypothesis as to what constitutes an adequate diet. It is, that in addition to the long recognized dietary factors, there must also be present *two* as yet unidentified substances or groups of substances. One of these is associated with certain fats (butter fat, egg yolk, and fats of the glandular organs, as the kidney and liver).<sup>26</sup> The other of these is never associated with fats but is widely distributed in natural foods and can be isolated as a concentrated but not pure substance by extracting natural food stuffs with either water or alcohol; this aqueous or alcoholic extract contains the substance that cures polyneuritis.

Upon the basis of their solubilities, McCollum and Kennedy in 1916<sup>27</sup> proposed for these two substances the names "Fat soluble A" and "Water soluble B."

Of these two, the *water soluble B* protects against and cures beri-beri. A deficiency of *fat soluble A* in a diet is indicated, as Osborne and Mendel<sup>28</sup> showed in 1913, by the development of a pathological condition in the eyes now known as xerophthalmia. Mori<sup>29</sup> had described (1904) 1,400 cases of this disease among children in Japan in a time of food shortage. It was relieved by administering chicken liver, for Japan, as a rule, has no dairy products. The same disease

in man has been described also elsewhere by other writers.<sup>30</sup> Besides these two *vitamines*, Drummond in 1918<sup>31</sup> proposed the recognition of a third, "*water soluble C*," postulated to exist in those foods that prevent or cure scurvy. This, of course, amounts to little more than a rewording of Dr. Barlow's view previously referred to, that scurvy is the result of a deficiency in some nutritive substance and of Funk's hypothesis. McCollum<sup>32</sup> protested vigorously against such an assumption and has given experiments to show that scurvy was, to his mind, accounted for by the packing of the caecum of the guinea pigs used in the experiments with putrefying feces—for this occurs when they are fed on diets producing scurvy. He was able to protect guinea pigs against scurvy when on a diet that otherwise produces it, by the use of mineral oil, or a laxative such as phenol-phthalein, or an entirely artificial orange juice made from citric acid, cane sugar and inorganic salts. The unsatisfactory "texture" of the diet, and the lack of roughage in it have also been urged by McCollum, and he has further shown that the rat is not susceptible to scurvy. With Pitz<sup>33</sup> he maintained the view that scurvy in guinea pigs results from a bacterial invasion of the tissues as the result of injury to the cecal wall when the animals are debilitated. He was unwilling to grant that man and the guinea pig may require some specific protective substance in their diet that the rat does not require. To his mind there were but *two* deficiency diseases, and they were xerophthalmia, due to lack of *fat soluble A* and beri-beri, due to lack of *water soluble B*.

But the experiments with guinea pigs have multiplied enormously, for they are convenient experimental animals, and quite a literature on *water soluble C*, whether so called or not, has accumulated in recent years. The fact that the guinea pig is herbivorous whereas man is omnivorous does not seem to have interfered with pretty free generalization from the pig to man. McCollum's protest as to the lack of roughage in the diet has been met by experiments<sup>34</sup> in which it has been shown that the same weight of cabbage that when raw protects a guinea pig on a certain diet from scurvy, fails to protect the same pig on the same diet when the same weight of cabbage is first heated, and then fed.

Some of the other statements resting upon the guinea pig experiments may be regarded as open to grave doubt when



extended to man, for example, the statement that raw lean beef does not possess antiscorbutic properties<sup>35</sup>—a statement directly contrary to Dr. Barlow's experience with human beings. One may well ask the question whether raw lean beef could well be expected to be digested by a herbivorous animal like the guinea pig, and if not digested by the pig, how could it be expected to affect his scurvy? Stefansson,<sup>36</sup> after observing three cases of scurvy in his polar expedition, distinctly states that meat, and especially raw meat, prevented and cured scurvy. Before we can feel entirely satisfied that we have learned much about human scurvy through animal experimentation, it would seem that some omnivorous animal susceptible to scurvy should certainly be used.<sup>37</sup>

On the other hand quite a number of the facts brought to light in the guinea pig experiments are most interesting. It has been shown that the extent to which milk possesses antiscorbutic properties varies with the food of the cow.<sup>38</sup> This is in line with McCollum's observation that the suckling suffers if the diet of the mother is deficient in *fat soluble A* or in *water soluble B*.<sup>39</sup> Other interesting facts that may be mentioned are: the desiccation and the cooking of cabbage and potatoes is accompanied by a loss in the supposed *water soluble C*, but the loss is less if the vegetables be first plunged in boiling water; fresh young carrots are more active than old stale carrots; fresh pasteurized milk is more active than stale pasteurized milk; etc.<sup>40</sup>

In regard to *water soluble C*, it may be said that tomato juice is active as well as lemon and orange juices. It has been shown that lemon juice retains its activity after removal of the free citric acid and other free acids.<sup>41</sup> It is possible to concentrate this activity of lemon juice even to seven times the natural amount.<sup>42</sup> By distillation of orange juice under reduced pressure at 40 degrees C. it is possible to obtain a solid residue which is very active; this activity is not appreciably diminished when the substance is kept as long as six months if kept in a dry atmosphere at room temperature.<sup>43</sup> These experiments indicate that "the potent fruit juices can be suitably preserved for clinical use."<sup>44</sup>

Drummond (1918)<sup>45</sup> gives two tables that are worth having. Undoubtedly further experiments will necessitate changes in them as our knowledge of vitamins becomes broader and more definite, but they put the information avail-

able at that time (1918) in as useful a form as it can well be put. The first table gives the stability of the three vitamins toward heat, toward alkalis and toward acids. The second table gives the distribution of the three vitamins in the common natural food stuffs. Another table also has been published,<sup>46</sup> but in it the authors have assumed the identity of fat soluble A and an antirachitis factor—against which assumption notable objections have been raised.<sup>47</sup>

## DRUMMOND'S TABLES.

TABLE I.

A="FAT SOLUBLE A."  
B="WATER SOLUBLE B."  
C="WATER SOLUBLE C."

	A (54, 55)	B (57)	C (60, 62)
Stability to temperature .....	Stable at 100° C. probably stable at 140°	Comparatively stable at 100°; slowly destroyed at 120° and above.	Gradually destroyed above 50° C.; rapidly destroyed above 80° C.
Stability to alkalies .....	Stable when cold; probably stable when hot.	Slowly destroyed when cold; rapidly destroyed when hot.	Rapidly destroyed even when cold.
Stability to acids .....	Probably stable.	Comparatively stable.	Comparatively stable below 50°.

TABLE II.

\* = Some.  
\*\* = More.  
\*\*\* = Most.  
? = Doubtful.  
— = Deficient.

	A	B	C
Wholemeal bread .....	*	**	—
Yeast, dried .....	*?	***	—
Yeast, extract, commercial .....	—	***	—
Cabbage, fresh (55, 57, 52, 61, 60) .....	**	*	***
Cabbage, dried .....	**	*	—
Spinach (52, 57) .....	**	*	***
Potatoes (57, 48) .....	—	*	**
Oranges (60) .....	—	—	***
Tomatoes (57, 41, 63) .....	?	*	?
Onions (57) .....	?	—	***
Apples (green) (60) .....	?	—	***
Lettuces (60) .....	*	—	***
Peas, dry (57, 52) .....	?	*	—
Peas, fresh (53, 60) .....	*	*	***
Malt extract .....	—	—	?
Milk (56, 60, 65) .....	**	**	*
Butter (48) .....	***	—	—
Cream .....	**	*	*?
Separated milk .....	—	**	*

	A	B	C
Whey .....	—	**	*?
Egg yolk (52) .....	***	*	?
Egg, white .....	—	*	?—
Beef fat .....	**	—	—
Lard .....	—	—	—
Vegetable oils .....	—	—	—
Animal fat margarines (48) .....	*	—	—
Vegetable oil margarine (48-50) .....	*	—	—
Lean meat (60) .....	—	—	*
Liver (51) .....	**	**	—
Heart, kidney (51) .....	*	*	—
Pancreas .....	*	**	—
Brain .....	*	**	*?
Lean fish, e.g., cod .....	—	*	—
Fat fish, e.g., herring .....	*	*	—
Fish roe .....	*	**	—
Cod liver oil .....	***	—	—
Fish body oils (49) .....	**	—	—
Wheat, whole grain (57, 66) .....	*	**	—
Wheat, embryo .....	**	***	—
Wheat, endosperm .....	—	—	—
Wheat, bran .....	—	*	—
Rice, polished (57) .....	—	—	—
Rice, whole grain .....	*	**	—
White bread (57) .....	—	—	—

In addition to beri-beri and scurvy, Funk also ascribed rickets<sup>69</sup> and pellagra to deficiency of some *vitamines*. Regarding rickets, McCollum states<sup>70</sup> that its relation to diet is not clear, but that it is *unnecessary* to invoke the aid of any hypothetical *vitamine* to a lack of which the disease may be attributed. The well known deficiencies in the dietaries of those among whom rickets occurs, together with the injury to the intestine which is nearly always indicated by the distended abdomen, the occurrence of rickets only in early life, and its frequent association with infectious diseases, separately or jointly suffice for explanation of rickets without recourse to an assumed *vitamine*.<sup>71</sup>

Regarding pellagra,<sup>72</sup> it may be said that Goldberger's<sup>73</sup> studies in the South, carried out for the United States Public Health Service, seem to have established beyond doubt the conclusion that Roussel<sup>74</sup> reached in 1866, namely, "Without dietetic measures, *all remedies, fail.*" Goldberger's observations leave no doubt that it is caused by a restricted diet and cured by a balanced diet. McCollum points out the deficiencies in the diet as three: insufficient proteins and these of poor biologic value, insufficient fat soluble A, and insufficient calcium in the mineral constituents of the diet.<sup>75</sup> McCollum (1919) has shown<sup>76</sup> that attempts to produce in animals a condition analogous to pellagra were unsuccessful; that pel-



lagra is, in his opinion, probably due to an infectious agent: that a faulty diet, in his opinion, does not cause pellagra, but may produce a susceptibility to it. A proper diet, McCollum states, would eliminate the predisposition to pellagra and cause the disappearance of the latter.

The importance of the problem presented by pellagra must not be underestimated. Although it was first recognized in America in 1864, in 1917 there were estimated to be 165,000 pellagrins in the United States.<sup>77</sup> Goldberger's experiments or studies may be regarded as parallel to Eijkman's studies that were the forerunners of our knowledge of vitamins. Goldberger, however, was unable to work with the vast number of persons included in Eijkman's study; he did work, however, on the inmates of two orphanages and one State sanitarium, in two widely separated localities, observing and controlling the diet of about 268 pellagrins. Goldberger also succeeded in producing pellagra in about 50 per cent. of a group of 12 prisoners—volunteers at the Mississippi State Penitentiary, merely by limiting the diet. Possibly some omnivorous animal susceptible to pellagra and suited to laboratory experiments can be found<sup>78</sup> which will serve for experiments as carefully controlled and as reliable as those of McCollum on xerophthalmia and polyneuritis. Until then it must remain short of safe to affirm or to deny Funk's assumption that pellagra results from deficiency of some vitamine. The case stands in a less satisfactory condition<sup>79</sup> than that of scurvy, for although the guinea pig is not an entirely satisfactory animal some things of value undoubtedly are being learned by its *extensive* use. Further, scurvy is more readily studied in man, particularly in infants, than is pellagra.

Relations between vitamins and certain glands have been brought to light. Fat soluble A is reported absent from pancreas, thymus, and suprarenal glands.<sup>80</sup> Water soluble B is probably present in some glands, for avian polyneuritis is relieved by thyroxin, and by desiccated thyroid gland.<sup>81</sup> McCarrison<sup>82</sup> reports that upon feeding pigeons on autoclaved undermilled rice, that is, upon a diet deficient in water soluble B, the adrenals became much enlarged and showed an increase in adrenalin content. The other organs and glands underwent atrophy in the following order: thymus, testicles, spleen, ovaries, pancreas, heart, thyroid, liver, stomach, kidneys and pituitary. The manner in which the testicles are reduced and

the adrenals enlarged is particularly striking. There is a similar but less pronounced atrophy of the ovaries in females, and McCarrison quotes Vedder as saying that women afflicted with beri-beri fail to menstruate. With respect to water soluble C, McCarrison has later <sup>83</sup> shown that guinea pigs dying of scurvy have adrenals of approximately double the normal weight, but containing less than half the normal amount of adrenalin. McCarrison calls attention to the importance of a functional perfection of the glands to the growing child.

The pharmacology of vitamins from rice, spinach, nettle, cloves, cabbage, wheat, yeast, oats, flesh, and blood, has been studied extensively by Uhlmann.<sup>84</sup> The general conclusion is that vitamins are regulators of tone throughout the body.

It has been demonstrated that certain vitamins are also of fundamental importance in nutrition in the vegetable kingdom. The yeast plant is so sensitive to water soluble B that it is possible at will to cause a single yeast cell to produce twenty cells or several thousand cells in 24 hours simply by varying the content of this vitamin in the culture medium. The reproduction of the yeast plant has been proposed <sup>85</sup> as a simple and highly sensitive biological test for the detection and estimation of water soluble B. *One two-billionth of a grain* of material containing this vitamin is sufficient to produce "striking results" with yeast.

The addition of a vitamin to synthetic media makes normal growth of "*sclerotinia cinerea*" possible,<sup>86</sup> and it is held to play an essential part in the respiratory process of yeasts, pollen, fungus spores, etc. With *sclerotina*, a long list of nitrogen compounds, sugars, pectin, inorganic salts, and salts of organic acids, under various conditions of acidity, temperature, and light, were tried, but in all cases where the substances involved were pure and were not contaminated by mother liquor from a plant juice, growth either did not take place or was very weak.

Bacillary growth has also been demonstrated to depend, in some instances at least, upon vitamins. The influenza bacillus requires not only haemoglobin but also a vitamin-like substance.<sup>87</sup> It has been suggested that this bacillus, as well as the meningococcus, is unable to obtain from proteins the amino acids necessary for nutrition unless the necessary vitamin is present.<sup>88</sup>

Suggestions have been made regarding the chemical character<sup>89</sup> of vitamines. Birckner,<sup>90</sup> of the Bureau of Chemistry, U. S. Department of Agriculture, has inferred from his analyses of yolk of egg, milk, etc., that zinc exerts an important nutritive function. Stienbock suggested<sup>91</sup> that fat soluble A might be identical with one of the yellow vegetable pigments, but there seem to be too many apparent contradictions<sup>92</sup> to the suggestion to warrant the use of this idea even as a working hypothesis.

We may summarize, in closing, as follows: When the daily quantity of food required by man has been summed up in statements as calories, it has been an error to lose sight of the implicit assumption that the stated number of calories were to be derived from a varied and mixed animal and vegetable diet containing proteins from various sources, and also fats and carbohydrates of different origins, all in an unpurified form, and in fairly definite proportions to each other. The logical fallacy involved in the unqualified conclusion that a given number of calories produced by the physiological combustion of protein, fat and carbohydrate will enable man to live in health and to grow, is exposed beyond all chance of concealment. A key to the problem of the differences among diets of equal energy-content but of different origins, is offered in the idea of *vitamines*, which are substances or groups of substances whose nutritional effects are large and out of all proportion to their intrinsic values as to energy or mass. The absence of sufficient quantities of vitamines in diets has been suggested as the cause of xerophthalmia, beri-beri, scurvy, rickets and pellagra. Animal experimentation has already made it highly probable that xerophthalmia and beri-beri in man are true "deficiency diseases," due to the lack of vitamines known as "fat soluble A" and "water soluble B" respectively. Most writers lean toward the conclusion that scurvy is now shown to be a deficiency disease, due to the lack of a vitamine, "water soluble C."

The knowledge of vitamines, while in the making, must already be granted rank with the other knowledge generally recognized as of a character most fundamental to life and well being.



## BIBLIOGRAPHY

- 1 Since this paper was read, references to more recent literature have been added to it.
- 2 Rosenau; Preventive Medicine and Hygiene, 3d Ed., New York, 1917, p. 522.
- 3 The quarantine regulations of the port of Philadelphia include beriberi among the *quarantinable* diseases. Bergey; Principles of Hygiene, 6th Ed., Phila., 1918, p. 236. Cf. Goldberger; U. S. Public Health Reports, 1914, p. 1083. Sambon, Abstr. Jour. Amer. Med. Asso., 55, p. 361, ascribes pellagra to infection by a protozoan distributed by a species of sand-fly.
- 4 Cf. Siler, Garrison and McNeal; Arch. of Int. Med., 14, p. 453, 1914; Strong and Crowell; Philippine J. of Science, 1912, p. 271.
- 5 See *Pellagra*, W. B. Saunders Co., Phila., 1912.
- 6 Raubitschek; Berlin klin. Wochens, xxiii, June, 1910.
- 7 Lomborso, 1872; see Siler, et al., l.c., note 4.
- 8 Scurvy has frequently been ascribed to the absence of certain organic acids and salts. Cf. Bergey, l.c., p. 235.
- 9 Trans. Roy. Med. and Chir. Soc., lxvi, p. 159. Infantile scurvy had been described by Glisson in his Treatise on Rickets, 1051; Chendle in 1878 pointed out its identity with adult scurvy.
- 10 *Scurvy* is derived from the root in the Anglo-Saxon word *Sceorfan*, meaning to scrape.
- 11 Bradshaw Lecture, British Med. J., 1894.
- 12 Arch. path. anat., cxlviii, p. 523, 1897; Arch. f. Hyg., lviii, p. 150, 1906.
- 13 *Beri-beri* is derived from the Singhalese word *beri*, meaning weakness.
- 14 Rosenau, l.c., p. 652.
- 15 Rosenau, l.c., p. 649.
- 16 *Beri-beri* may also be caused by limited diets not containing rice. Its occurrence on certain Norwegian ships has been recorded by Holst, Jour. of Hyg., 1907, p. 619; on the coasts of Newfoundland and Labrador, by Little, J. Amer. Med. Asso., 1912, p. 2029, and Lovelace, *Ibid*, 2134.
- 17 Lancet (London), 1910, p. 733. Study No. 12, Inst. of Med. Research, Federated Malay States, 1911.
- 18 Rosenau, l.c., p. 651.
- 19 Bischem, Ztschr., xxii, p. 452, 1909. Ztschr. f. Biol., lvii, p. 135, 1912; lix, p. 366, 1912.
- 20 Arch. f. Schiffs. u. Tropenhyg., Biehft, viii.
- 21 Lancet (London), 1911, p. 1266. Funk gives a summary of the literature in J. State Med., xx, p. 341, 1912, and describes the physical and chemical properties of his crystallized vitamine on p. 346. Cf. Funk and Macallum, Jour. Biol. Chem., xxiii, p. 419, 1915; and Biochem. Bull. iv, p. 304, 1915.
- 22 Newer Knowledge of Nutrition, New York, 1919, p. 94: "The evidence that the other diseases that he (Funk) included in the class of 'deficiency' diseases are due to the lack of specific complexes, was of the nature of *clinical* observations rather than well controlled experiments." On p. 33, however, McCollum says: "It (the vitamine theory of Funk) in reality rested only upon suggestive *chemical* evidence." The paradox in McCollum's strictures upon Funk may be merely apparent and not a real contradiction.
- 23 Willcock and Hopkins; J. Physiol., xxxv, p. 88, 1906; Hopkins, *Ibid*, xlv, p. 425, 1912.
- 24 J. Biol. Chem., xxiv, p. 491, 1916.
- 25 J. Biol. Chem., xv, p. 167, 1913.
- 26 Cf. "Nutritive Factors in Animal Tissues," Mendel and Osborne; Proc. Soc. Exp. Biol. Med., 15, p. 71, 1918.
- 27 J. Biol. Chem., xxiv, p. 491, 1916.
- 28 *Ibid*, xvi, p. 431, 1913.

- <sup>29</sup> Jahrb. Kinderheilk., lix, p. 175, 1904.
- <sup>30</sup> Block, J. Amer. Med. Asso., lxxviii, p. 1516, 1917. Czerny and Keller, Des Kindes, Leipzig, 1916, 2, p. 67. Cf. McCollum, l.c., p. 91 ff. In Biochem. J., 13, p. 103, 1919, Bulley challenges the statement of McCollum, Simmonds and Parsons, and asserts that his experience leads him to believe that xerophthalmia is due to an infection that is encouraged by a diminished resistance due to diet.
- <sup>31</sup> Lancet, cxcv, p. 482, 1918.
- <sup>32</sup> McCollum, l.c., p. 96 ff.
- <sup>33</sup> J. Biol. Chem., xxviii, p. 211 and p. 253; Ibid, xxix, p. 341 and p. 521; Ibid, xxx, p. 13; Ibid, xxxi, p. 229.
- <sup>34</sup> Givens and Cohen; J. Biol. Chem., xxxvi, p. 144. Cohen and Mendel; Proc. Soc. Exp. Biol. and Med., May 15, 1918; J. Biol. Chem., xxxv, p. 425.
- <sup>35</sup> Dutcher, Pierson and Biester, Science, N. S., Vol. 1, p. 184; Vol. II, p. 70.
- <sup>36</sup> J. Amer. Med. Asso., lxxi, p. 1715, 1918.
- <sup>37</sup> Harden and Zilva have shown that rats on a diet containing an antiscorbutic grow better than those from whose diet this factor is absent. Biochem. Jour., 12, p. 408, 1912.
- <sup>38</sup> See Note. 34.
- <sup>39</sup> Newer Knowledge of Nutrition, New York, 1919. Chapter vi, "The Nursing Mother as a Factor of Safety in the Nutrition of the Suckling."
- <sup>40</sup> J. Amer. Med. Asso., lxxiii, p. 338, 1919.
- <sup>41</sup> Harden and Zilva; Biochem. J., 12, p. 259, 1918.
- <sup>42</sup> Harden, Zilva and Still; Lancet, I, p. 17, 1919.
- <sup>43</sup> Harden and Robinson; Jour. Army Med. Corps, Jan. 1919.
- <sup>44</sup> J. Amer. Med. Asso., lxxiii, p. 272.
- <sup>45</sup> See Note 31.
- <sup>46</sup> Hopkins and Chick; Lancet, 2, p. 28, July 5, 1919.
- <sup>47</sup> Hess and Unger; Jour. Amer. Med. Assoc., 74, p. 217, 1920.
- <sup>48</sup> Steenbock, Boutwell and Kent; J. Biol. Chem., 3, p. 517, 1918. McCollum, Simmonds and Parsons; Ibid, 36, p. 197, 1918.
- <sup>49</sup> Drummond; Biochem. J., 13, p. 81, 1919.
- <sup>50</sup> Halleburton and Drummond; Jour. Physiol., 51, p. 235, 1917.
- <sup>51</sup> Osborn and Mendel; J. Biol. Chem., 34, p. 17, 1918.
- <sup>52</sup> Osborn and Mendel; Ibid, 37, p. 187, 1919.
- <sup>53</sup> McCollum, Simmonds and Parsons; Ibid, 37, p. 287, 1919.
- <sup>54</sup> Steenbock, et al., note No. 48.
- <sup>55</sup> Delf; J. Biol. Chem., 12, p. 416, 1918.
- <sup>56</sup> Osborne, Mendel, Ferry and Wakeman; J. Biol. Chem., 34, p. 537, 1918.
- <sup>57</sup> Osborne and Mendel, J. Biol. Chem., 39, p. 29, 1919.
- <sup>58</sup> Chick and Hume, J. Biol. Chem., 39, p. 203. Same, Proc. Roy. Soc., 90-B, p. 60, 1917.
- <sup>59</sup> Sullivan and Voegtlin; Proc. Soc. Biol. Chem., J. Biol. Chem., 24, xvi, 1916. Osborne, Wakeman and Ferry; Ibid, 39, p. 35, 1919. Daniels and McCherg; Ibid, 37, p. 201, 1919. McCollum and Simmonds; Ibid, 33, p. 55, 1919.
- <sup>60</sup> Chick, Hume, Skelton and Smith; Lancet, 735, Nov. 1918.
- <sup>61</sup> Chick and Rhodes, Lancet, 774, Dec. 7, 1918.
- <sup>62</sup> Hess and Unger; J. Biol. Chem., 38, p. 293, 1919. Same; Proc. Sec. Expl. Biol. Med., 16, p. 1, 1918.
- <sup>63</sup> Dried tomatoes are still active. Givens and McCluggage; J. Biol. Chem., 37, p. 253, 1919.
- <sup>64</sup> Cooked potatoes. Food War Committee; Lancet (London), 736, Nov. 1918. Brit. Med. J., 2, p. 28, July 7, 1917. Hess; J. Amer. Med. Assoc., 71, p. 941, 1918.
- <sup>65</sup> Raw, pasteurized and boiled milk. Chick, Hume and Skelton; Lancet I, Jan. 5, 1918. Commercial condensed milk. Hart, Steenbock and Smith; J. Biol. Chem., 38, p. 305, 1919. Dried milk. Hess and Unger; Ibid, 38, p. 293, 1919.

- <sup>66</sup> Voegtlin, Lake and Meyers; Amer. J. Phys., 48, p. 504, 1919.
- <sup>67</sup> McCollum, Mendel, Murlin, Taylor, Clowes, Henderson, Prescott, Bancroft and Mendenhall have been appointed by the National Research Council as members of an Advisory Board for the American Institute of Baking at Minneapolis, Minn., to work with it in solving the fundamental problems which are concerned with baking fermentology, and with the production of bread that satisfies every need of human nutrition. Ind. Eng. Chem., 12, p. 203, 1920.
- <sup>68</sup> Data relating to vitamine contents of other vegetables may be found as follows: Carrots; Denton and Kohman; J. Biol. Chem., 36, p. 249, 1918; also ref. 57; also ref. 61. Bananas; Sugiura and Benedict; Ibid, 36, p. 171, 1918; Turnips, ref. 59, O. & M.; Beets, ref. 59, O. & M. Dried egg, ref. 52. Milk solids; ref. 52. Navy beans; ref. 52. Grapes; ref. 60. Orange peel, ref. 60. Lemon juice; ref. 60. Lime juice, ref. 60. Swede, ref. 61. Dried lemons C. Delf and Skeleton; Biochem. J., 12, p. 448, 1918. Cotton seed oil; Palmer and Eckles; Missouri Agr. Exp. Sta. Res. Bull., 10, p. 361, 1914. McCollum, Simmonds and Pitz.; Amer. J. Phys., 41, p. 361, 1916. Rhubarb; Pierson and Dutcher; Science N. S. li, p. 70.
- <sup>69</sup> Word derived from obsolete English *wrick* or *rick*, meaning to twist.
- <sup>70</sup> Newer Knowledge of Nutrition, p. 111.
- <sup>71</sup> Since this paper was read, Hess and Unger, Jour. Amer. Med. Assoc., lxxiv, p. 217 ff, 1920, show by experimental results in human infant-feeding that fat soluble A is not the "much sought for anti-rachitic factor." They emphasize the existence of a "prenatal factor" in rickets, although it seems to me that some of the effects of vitamine deficiency have been amply demonstrated in McCollum's experiments to be prenatal. The striking facts that in rickets strong, healthy babies are frequently to be met with, and that rickets can be brought about by over-feeding, are dwelt upon. Neither scurvy or beri-beri can be produced by over-feeding. Mellanby's belief, Lancet 1, p. 407, 1919, that dogs deprived of fat soluble A develop rickets, is open to question, according to H. and U. The supposed identity of fat soluble A and the anti-rachitic factor affects the usefulness of Hopkin's and Chick's table. Such tables, H. and U. assert, are inexact and misleading, if in formulating such tables and in using them we lose sight of the fact that "we cannot regard (these) foods as possessing a standard antiscorbutic value—not even in an approximate sense." See also Hess and Unger; Ibid, 69, p. 1583, 1917.
- <sup>72</sup> Derived from Italian *pelle*, skin, and *agra*, rough. The synonym "Alpine Scurvy" is suggestive.
- <sup>73</sup> U. S. Public Health Reports, 1914, p. 1683, p. 2821. Ibid, 1915, p. 3117, p. 3336. J. Amer. Med. Assoc., lxvi, p. 471, 1916.
- <sup>74</sup> "Traité de la Pellagra, etc.," Paris, 1866, p. 529.
- <sup>75</sup> J. Biol. Chem., xxxii, p. 181, 1917. Ibid, xxxiii, p. 55, 1918. Cf. Henry; Ann. Rep. Wis. Agr. Exp. Sta., 1889, p. 15.
- <sup>76</sup> Proc. Amer. Phil. Soc., 58, p. 41, 1919.
- <sup>77</sup> Newer Knowledge of Nutrition, p. 103.
- <sup>78</sup> Dogs were used by Chittenden and Underhill; Amer. J. Phys., xlv, p. 13, 1917, and were found to develop symptoms strikingly suggestive of pellagra in man.
- <sup>79</sup> Since this review was read, McCollum has stated that pellagra is an infectious disease which, "like tuberculosis, is of relatively little virulence." It attacks only those whose vitality is lowered. The most common cause of lowered vitality appears to be faulty selection of food. "Only a year ago in a conference with Dr. Goldberger he assured me that it was his conviction that any diagnosis of pellagra in . . . an individual who could be shown to have taken the least amount of milk within the last six months was a faulty diagnosis." McCollum, in an address before



- the "Boston Milk Conference," and reported in "The Milk Dealer," Jan., 1920, p. 18 ff. Cf. Proceedings, Twelfth Annual Convention of the International Milk Dealers' Association, Chicago, 1919.
- <sup>80</sup> Emmett and Luros; *J. Biol. Chem.*, 38, p. 441, 1919.
- <sup>81</sup> Dutcher; *Ibid.*, 39, p. 63, 1919.
- <sup>82</sup> *Indian Jour. of Med. Research*, vi, p. 275, 1919.
- <sup>83</sup> *British Med. Jour.*, p. 177, Aug. 16, 1919. Quoted by Armstrong; *J. Roy. Soc. Arts*, lxxvii, p. 687, 1919. Also, *J. Amer. Med. Assoc.*, 73, p. 1381, 1919. Cf. Miles, The sex expression of men living on a lowered nutritional level, *J. Nerv. and Mental Dis.*, 49, p. 208, 1919. Cf. *J. Amer. Med. Assoc.*, 73, p. 1228, 1919.
- <sup>84</sup> *Ztschr. Biol.* 68, p. 419 and p. 457, 1918. In *Arch. Pediatrics*, 36, p. 80, 1919, Muckenfuss shows that water soluble B is present in human urine, and also in ox-bile.
- <sup>85</sup> Williams; *J. Biol. Chem.*, 38, p. 465, 1919. Also see Bachmann, *ibid.*, 39, p. 235, 1919. Osborne and Mendel; *J. Biol. Chem.*, 37, p. 187, 1919, show yeast to be very rich in water soluble B. Chick, Hume, Skelton and Smith; *Lancet*, 1918 (Nov.), p. 735, show that water soluble C is absent from yeast.
- <sup>86</sup> Willaman; *Journ. Ind. and Eng. Chem.*, 10, p. 863, 1918. Since this paper was read, Willaman has printed a full account of his work, *Journ. Amer. Chem. Soc.*, 42, p. 549, 1920.
- <sup>87</sup> Davis; *J. Inf. Dis.*, 21, p. 392, 1917; 23, p. 248, 1918.
- <sup>88</sup> Lloyd; *J. Path. Bact.*, 21, 113, 1916. Cf. Shearer; *Lancet*, 1917, p. 59. Pacini and Russell, *Journ. Biol. Chem.*, 34, p. 43, 1918.
- <sup>89</sup> Voegtlin, Lake and Meyers; *U. S. Pub. Health Reports*, 33, p. 647, 1918. The total phosphorus content of corn and wheat foods is a fairly satisfactory index of the amount of fat soluble A and water soluble B contained in these foods. Also, *ibid.*, 471, p. 49, 1919.
- <sup>90</sup> Birckner; *J. Biol. Chem.*, 38, p. 191, 1919.
- <sup>91</sup> Steenbock; *Science*, N. S., vol. 1, p. 352, 1919. Cf. Osborne and Mendel; *J. Biol. Chem.*, 20, p. 379, 1915.
- <sup>92</sup> Palmer; *Science*, N. S., vol. 1, p. 502, 1919. Cf. Steenbock, Boutwell and Kent; *J. Biol. Chem.*, 35, p. 517, 1918. Palmer and Eckles, *ibid.*, 17, p. 211, 223, 237, 245, 1914.

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CHRONIC TRIGONITIS IN THE FEMALE; A NEW METHOD OF TREATMENT. PRELIMINARY REPORT.—H. E. Lindeman (*Surg., Gyn. and Obstet.*, 1920, XXX, 64) believes chronic trigonitis to be one of the chief factors in the production of an irritable condition of the bladder in females. Its etiology is unknown. The symptoms consist of increasing frequency of micturition, a constant desire to urinate, and a sensation as if the bladder had not been completely emptied. The condition runs a course covering years, and becomes gradually worse and worse. The capacity of the bladder is commonly quite large; and except in the trigone, the walls of the organ, when looked at through the cystoscope, appear normal. The trigone, however, is dark red, swollen and cloudy, and shows many minute blood-vessels. Often red spots are seen over the trigone, and sometimes small cysts. The mucosa appears thickened and velvety. Treatment with nitrate of silver solutions is not very satisfactory, although giving temporary relief in some cases. The author employs quinine and urea, which he injects into and under the mucosa of the trigone by means of a needle and canula that he has devised for use with the Brown-Buerger catheterizing cystoscope. The solution, which varies from 2 to 5 per cent., is colored with methylene blue. From two to four injections, at intervals of one to two months, are required to bring about almost complete relief in even the worst cases. The quinine causes a deposit of fibrin around the blood vessels. This strangulates them, and brings about a nearly normal appearance in the mucous membrane of the trigone.

**THE DOMINANT THERAPEUTIC METHOD OF THE PRESENT.**

BY

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(Read before the Maryland State Homœopathic Medical Society.)

HOMŒOPATHY has been tested at the bedside through more than a hundred years; and has not been found wanting.

One of the difficult things is to make one's inclinations always square with his philosophy. The gratification of a desire is not always consistent with the greatest good of the greatest number, or even with the greatest good of the individual. To sit in judgment upon some new thing that antagonizes a social convention, or threatens to dethrone some cherished belief or disbelief, calmly weigh the evidence and decide to accept the innovation as one of the verities, is beyond the average human mind. While there are doubtless many minds above this mediocre average, yet the mind of the physician does not typify such altruistic philosophy. Furthermore, investigation in all the various fields of medical endeavor during the past century, reveals the fact that the dominant medical school—and I think "dominant" is here used advisedly—contains a much smaller proportion of liberal minds than the minority not included in this class of self-constituted "authorities." In this minority may be found the avowed practitioners of homœopathy, those who endeavor to prescribe in accordance with the principle of similars.

While it is a fact that the practitioners of homœopathy are not limited to those who confess a belief in the method, yet those only who do make such a confession must logically be regarded as forming a distinctive class, and when mention is made of the homœopathic school it is this body of practitioners which is so characterized.

The number of practitioners in this avowed distinctive body, however, is not a true index of the gross number of individuals who daily demonstrate the great principle. It is questionable if there is one physician in general practice who does not almost daily prescribe some therapeutic agent in accordance with homœopathy, whether he may recognize the fact or not. He may even be ignorant of the motto of the followers of Hahnemann, even of the name of the great reformer,

and know nothing whatever of the system of philosophy upon which practical homœopathy rests. For that matter, however, there are some of those of the avowed school of homœopathy who may not be quite clear on the point of definitions, and especially as to the full significance, both stated and implied, of the motto under which the school is supposed to win its victories. The epigrammatic phrasing of the fact concerning the therapeutic power of homœopathy, may be divided into four distinct statements:

First, *similia similibus curentur*, similars by similars may be cured, which is to be regarded as a tentative statement suggesting a possibility capable of fulfilment under proper conditions; the proper conditions being the administration of a drug which we know to have a pathogenic similarity to the disease condition of the patient to whom it is given. Under such conditions we may expect a cure.

Second, having complied with the foregoing conditions, and experiencing the expected results, we are then in position to assert that *similia similibus curata sunt*, similars by similars have been cured; which experience, more than one hundred years ago, led Hahnemann to adopt as a motto—

Third, *similia similibus curantur*, similars by similars are cured. We are now in position to make a *previsional* statement, a statement which savors of the prophetic; but being based upon facts many times verified it becomes a link in this chain of epigrams, and takes its logical place as the

Fourth, giving us inspiration by the certainty that *similia similibus curata erunt*, similars by similars will be cured, and consequently completing what may be considered the creed of the practical student of homœopathy. These four epigrams may, therefore, be stated in the following sequence:

*Similia similibus curentur* having been satisfactorily demonstrated, it may be truthfully stated that *similia similibus curata sunt*, and, therefore, it in turn becomes correct, even though regarded as a little radical by some, to say *similia similibus curantur*, and finally, past experience fully justifies a belief in our concluding epigram, *similia similibus curata erunt*; all of which briefly stated simply means that homœopathy may cure, has cured, does cure, and will cure.

These epigrams are not mere theory, for research reveals the fact that the belief in the therapeutic efficacy of homœopathy is founded on experience, and experience furnished not



only by Hahnemann and other avowed practitioners of the system, but also by the testimony of the unbelieving. Much has been written which fully substantiates this statement; but at this juncture in our own history it will be well to again glance over the field, "lest we forget" how intimately blended and incorporated in the therapeutics of the older school of medicine is the practice of homœopathy.

From the writings of such moderns as Shoemaker, Hare, Bartholow, H. C. Wood, Cushny, Ringer, Butler and Potter, we find the following agents recommended as useful in the treatment of the accompanying conditions, all of which may also be found scattered throughout the literature of the homœopathic school. Thus condensed, the compilation may be characterized as—

The "Allopathic" Physician's Homœopathic Repertory.

*Abscess.*—Calcium sulphide is generally used. In the early stage of development "it may often be modified by the use of aconite." *Phytolacca* is also suggested; "mastitis especially often yielding to the internal use of the fluid extract, combined with the local application of an ointment containing *phytolacca*."

*Angina Simplex* may call for aconite, belladonna, or hamamelis.

"In *aphonia* of hysterical women," *ignatia* is recommended.

In *asthma*, *ipêcac*, *lobelia* and *nux vomica*, are submitted for selection.

*Bronchitis*, it is suggested, may require belladonna, *bryonia*, *chamomilla*, *conium*, *drosera*, *dulcamara*, *ipêcac*, *lobelia*, *lycopodium*, *sanguinaria*, *senega*, or even *terebinth*.

For *bruises*, we are told that *arnica* should be used; and this drug is also suggested in cerebral concussion.

*Catarrh of the respiratory tract*, in its incipiency, suggests *euphrasia* to our friends; and when the "upper respiratory tract" is involved "*hydrastis* is a valuable remedy." *Eucalyptus* is a most valuable remedy in chronic inflammations of the mucous membranes; and it has also been found that aconite is useful in acute throat troubles of children. Another discovery is that "*nux vomica* has great effect upon a dry cold in the head;" and "in acute nasal catarrh with profuse watery discharge" belladonna is useful; and "*pulsatilla* is excellent

in subacute inflammation of the nasal passages, with offensive muco-purulent discharge."

In *catarrhal croup*, acon., ipec., and lobelia, should demand attention.

In *Cholera Asiatica* camphor is prescribed; *a la* Rubini, it may be inferred.

In *Cholera infantum*, arsenic, copper sulphate, and ipecac, are recommended for trial.

We are also informed that *conjunctivitis* yields to the persuasive influence of belladonna, euphrasia, pulsatilla, or staphisagria, as the individual case may require.

*Constipation*, we are informed, may call for nux vomica; and "When the passages are dry and friable and resemble those of a dog in character, bryonia is of great value."

For *cough*, we are told we have curative agents in aconite, belladonna, conium, drosera, hyoscyamus, ipecac, lobelia, pulsatilla, and even senega.

*Custitis* calls for cantharis or terebinthina.

*Diarrhoea* may call for podophyllum, if it be a "morning diarrhoea;" rumex is also recommended for "morning diarrhoea," in corroboration of Cowperthwaite, perhaps. For the diarrhoea "of children from teething," chamomilla is recommended, while veratrum album "has been used with advantage in the vomiting and purging of summer diarrhoea;" and, remarkable as it may seem, bichloride of mercury should be prescribed "if the passages are slimy or bloody." Attention is also called to aconite, arsenic, dulcamara, ipecac, magnesium sulphuricum, and pulsatilla, for various forms of diarrhoea.

*Gonorrhoea*, with all its obstinacy, does not deter our friends from using aconite, cantharides, and cannabis indica, in its treatment; or from asserting that hydrastis is "one of the best remedies" for that condition.

*Haemorrhage* suggests byronia, arnica, hamamelis, or erigeron, if it be from the nose; ipecac and hamamelis, if from the lungs, and the latter in the form of a distilled extract as a high enema in haemorrhage from the bowel; and for haematuria, terebinth should be prescribed.

*Headache*, when it occurs "in young persons, often due to overwork, with pain in the eyeballs and forehead and a sensation as if the orbits were too small for the eyeballs, belladonna is of service." Also "cimicifuga, if due to eyestrain," and gelsemium, if due to nervous troubles or eyestrain." In sick headache, "nux vomica."

*Incontinence of urine* requires belladonna, cantharis, hyoscyamus, or rhus aromatica, according to indications.

*Intestinal colic*, we are told, will yield when arsenic, belladonna, chamomilla, and nux vomica, are prescribed, presumably when indicated.

For *Measles*, assurance is given that aconite and pulsatilla may be used with confidence.

*Nausea* is a condition calling for ipecac—strange as it may seem—pulsatilla, or cocculus indicus.

*Nephritis*, when acute, may require aconite, or cantharis.

*Neuralgia* calls for "aconite when there is febrile excitement;" belladonna may give relief "in tic-douloureux and sciatica;" "cimicifuga, and gelsemium, do good in simple neuralgia of the fifth, and in ovarian neuralgia," and the former also "relieves the pains of dysmenorrhoea when of the congestive variety."

*Pertussis* requires such agents as acon., bellad., ipecac, and even at times drosera.

For *pleurisy* we are told that aconite should be prescribed "previous to the stage of effusion;" that bryonia and veratrum viride may also be found useful in this disease.

In *pneumonia* it is suggested that aconite be given "before exudations have taken place;" that veratrum viride be given "in the very incipency;" that ipecac is indicated "particularly in the congestive and declining stages of the disease;" and that such other remedies as belladonna, gelsemium, phosphorus, and tartar emetic be given due consideration.

*Rheumatism* may also call for aconite; and "in acute inflammatory rheumatism cimicifuga has been highly recommended." Our old friends bryonia, dulcamara, caulophyllum, arnica, and even rhus tox., have also received the endorsement of our confreres in this malady.

In the treatment of *scarlatina* aconite and belladonna stand out in prominent recommendation, to say nothing of rhus tox. and veratrum viride.

*Sciatica* claims the attention of aconite, belladonna, cimicifuga, gelsemium and rhus tox., apparently according to individual indication.

In *tonsillitis*, *pharyngitis* and *laryngitis*, aconite is strongly recommended.

*Typhoid fever*, we are told, calls for such drugs as arnica, baptisia, gelsemium, and sometimes terebinth.



This is a meagre repertory, but as sketchy as it is, it is quite suggestive of the trend of therapeutic thought of our friends.

It would be most interesting to trace the prime origin of these recommendations for the use of drugs, but time, space and inclination forbid.

We now come to a comparatively new field of therapeutics, in which many members of both the dominant schools of medicine are active workers. I refer to the extensive hypodermic use of the various cultured micro-organism. Like the drugs above noted, these agents are prescribed by physicians of all therapeutic views, and both prophylactic and curative results follow no less frequently than when the indicated drug is given. These agents are known as anti-toxins, toxins, bacterins and sera. As the name implies, the anti-toxin acts directly upon the toxin which is causing the trouble, and apparently has little influence upon the general organism, simply destroying the toxin, and, therefore, does not act in accordance with any therapeutic principle, any more than does a chemical agent introduced into the organism for the purpose of neutralizing some other substance by direct contact, which otherwise might work disaster.

With the bacterins, the sera and the toxins, it is different. These substances act definitely in accordance with some therapeutic principle, producing results by causing the organism to dispose of the intruding harmful agent. In fact, the bacterins, the sera, and the toxins of the various bacilli from which they are derived, when given to cure the conditions similar to those they cause, act in accordance with the principle of similars, it matters not by whom they are used. Whether they raise the opsonic index and stimulate the appetite of the physiological phagocytes of the given organism, or whether they act in some other manner, makes no difference whatever to the principle which controls their action. Incidentally, it may be mentioned that the same may be said of any and all dynamically acting drugs, as bryonia, phosphorus, or aconite, for example. It is by no means certain whether they act in accordance with Wright's theory, by a process of stimulation of the organism directly, or in some manner entirely unexplained; but whatever may be the true *modus operandi* the fact is evident that they do cause curative results when prescribed in accordance with the homœopathic principle.

In speaking of the agencies or agents that are homœopathic to certain conditions, we must not forget that homœopathy has to do with the dynamics of the organism only; and that for an agent to act homœopathically it must so influence the recuperative power of the organism—whether through the nervous system or the organic vitality of the blood—that health is restored in consequence of such influence. When a drug is given which acts *directly* upon some intruder, as in the case of tape worm, or any other of the great family of parasites, the destruction of the parasite is not due to the principle of similars; but when an agent is given which puts the organism into such a condition that causes the system to destroy or expel the parasite, then the principle involved may be that of homœopathy. It, therefore, becomes evident that all microbic diseases come under this classification.

So far as may be discovered from such accepted authorities as Nothnagel, Osler, Dieulafoy, Strümpell and Forchheimer, the fact that the human organism may by drugs be put into such condition as to repel the invading bacillus of typhoid and other microbic diseases, does not seem to have occurred. Is it not astounding that such men should not have availed themselves of the aid which could be obtained from the experience and observation of the avowed believers in homœopathy, among whom are many trained observers and expert practitioners of medicine.

The intent of the foregoing is not to suggest the limitation of all good therapeutics within the pale of homœopathy. No sensible physician will deny that all practitioners of all schools realize the fact that there are a number of ways of appealing to the recuperative force of the organism, besides the method formulated by Hahnemann; but the now established fact should not be forgotten, that like a theme of some great melody, the demonstration of homœopathy continuously recurs in the work of the physician of today, regardless of his polemics. In fact, this theme is so insistent that we may regard it as dominating whatever other methods and means may also be used by the rational practitioner of medicine.

In considering this question of the significance of the great therapeutic principle, we must not ignore that large contingent of the dominant school of medicine which minimizes the influence of drugs as curative agents. I refer to those who have been called therapeutic nihilists. It is true they do not

go to the extreme of the much older school of pure expectancy, typified in Sydenham, but they are only saved from this radical position by the more advanced methods of temporary alleviation taught by modern scientific experimentation.

A leader of this cult writes of typhoid fever: "There is no specific drug treatment." Of pneumonia he says: "Pneumonia is a self-limited disease, which can neither be aborted nor cut short by any known means at our command." Of appendicitis he writes: "There is no medicinal treatment of appendicitis. There are remedies which will allay the pain, but there are none capable in any way of controlling the course of the disease." Of mucous colitis: "Drugs are of little value." Of pleurisy: "Medicines are rarely required." Of acute Bright's disease: "No remedies, so far as known, control directly the changes which are going on in the kidneys."

Removal of concomitant conditions and painful symptoms is quite in order in the therapeutics of these authors, but no effort is made to investigate the reason why the homœopathic practitioner has such success in typhoid fever with baptisia, gelsemium, or rhus tox.; in pneumonia, with bryonia, veratrum viride, or phosphorus; in appendicitis, with belladonna, bryonia, or mercurius corrosivus; in colitis, with nux vomica, colocynth, or aloes; in pleurisy, with aconite, bryonia, or belladonna; or in acute nephritis, with apis, belladonna, or terebinth; all of which have been verified by the regnant old school authorities of the present, as we have seen. Assertions that there is no curative medicinal treatment for the conditions especially noted, simply shows ignorance of the real resources of materia medica.

This pessimistic attitude is quite in contrast with that of the more liberal subdivision of the older school of medicine, whom we have seen prescribing, in harmony with the views of the homœopathist. Fortunately for mankind, however, the pessimistic form a small minority. As a matter of fact, the average physician is desirous always of curing, or at least relieving his patient of suffering, and in this day of toleration and of liberty of thought he unhesitatingly accepts that which is for the best good of the patient, and of necessity he becomes a practitioner of homœopathy. This means that a large majority of the medical profession owe much of their success to the art of homœopathy.

Today there is much less discourtesy, ridicule of, and out-



spoken enmity to the believer in homœopathy than a few years ago. One of the causes of this modified attitude may be found in the general adoption of the bacterins, sera and toxins, to which reference has been made. The question of infinitesimal dosage is rarely mentioned between the schools, because both have become more reasonable on this point. There is greater toleration upon all subjects throughout civilization, and the believers in homœopathy, with few exceptions, now agree with Hempel, who long ago taught that "Homœopathy does not mean either small or large doses;" and those who have given homœopathy little thought are beginning to realize that the homœopathic practitioner is not such a bad fellow after all, and that he certainly does seem to have success in some conditions, especially in influenza. Investigation is one of the activities of the present day, and the investigating eye of science is with certainty turning to this field of therapeutics into which so many of all schools have been driven by the study of the relationship of pathogenic micro-organisms to the art of therapeutics.

Through many years we have heard the recurrent assertion of the extinction of homœopathy, but we continue skeptical as to the truth of the announcement; which reminds us of a similar statement concerning Mark Twain, made some years before his death, in correction of which the great humorist announced that the reports of his death had been greatly exaggerated.

No, homœopathy is not dead! Homœopathy was never more generally practiced throughout the whole medical profession than today. That branch of the medical profession known as the distinctive school of homœopathy may not be as vigorous as in days of yore; but homœopathy was never more vitally alive than it is today.

Those of our profession who are contemplating the wisdom of giving up the fight, and joining the ranks of the dominant school of medicine, are on the eve of a vital mistake. Why leave the victorious army? Now, when we have seen the enemy completely routed, captured and converted over to our art is not the time to lay down our arms, or even to rest. So much greater numerically are those who have opposed us in the past, and so energetic have they become in the field of therapeutics, that of a certainty they will take credit to themselves for all their great verifications of the principle of simi-

lars, unless we stand together and insist upon having the things of Caesar "rendered unto Caesar." Let us continue to represent that division of the medical profession which not only *practices* homœopathy, but which practices it intelligently, not for the purpose of antagonizing the ignorant, but steadily and quietly awaiting the day when the work of the great reformer, Hahnemann, shall be acknowledged by all medical practitioners, as has been the work of Bacon, of Harvey, of Priestley, of Cullen, of Davy, of Farraday, and all others who have lived to the advantage of the human race.

If, however, the desire to unite with the great majority be too strong to resist, follow the desire, but do not give up old affiliations. Yield, if you will, to the solicitations of your old enemies, but when you have entered their doors let your first act be to openly initiate among them an organization for the critical study of homœopathy, to which all who sincerely wish may be eligible. Or, better still, unite with the liberal of both schools for the purpose of organizing a national medical association—similar to the great national surgical organization now in existence—to which all educationally and legally qualified physicians may be admitted, regardless of school, sect or pathy.

Homœopathy has been tested at the bedside through more than a hundred years, and has not been found wanting. Homœopathy has been the "new thing" that threatened to dethrone cherished beliefs, and the orthodox school of medicine has sat in judgment upon this new thing, and through all the long century of progress the judge has not calmly weighed the evidence, but has adopted the attitude of the "average human mind" and not that of the trained expert, and homœopathy as homœopathy still stands outside the pale of conventions arbitrarily set by this unfair Sanhedrim of unwise men.

Fortunately for the human race, however, the more liberal who are not under the dominion of this ruling minority, have seen fit to enter the arena of homœopathy, and, though in most instances not aware of the significance of their act, have applied the principle of similars in their daily practice, thus hastening the day when our art will receive just and open recognition by all fair-minded medical thinkers.

This is no argument for exclusive homœopathy, no plea for sectarianism, for, as heretofore suggested, it is a fact that the recuperative force of the human organism may be aroused

by more means than one, and health restored by many different agencies and even different principles, according to the indication of each; but it is a plea for intelligent consideration of certain definite facts of therapeutic experience which stare all physicians in the face, and demand investigation at the hands of the unenlightened.

We have seen that drugs of all classes, animal, vegetable and mineral, are used by physicians generally in accordance with the homœopathic principle, and we have gone beyond what may be regarded as the legitimate drug field, and find the great bacterial world laid under contribution, and we have discovered that physicians generally are using the various sera, bacterins, and toxins, in the endeavor to prevent and cure disease, and these, too, we find bring about their characteristic good results in accordance with the great principle of similars.

In consequence of these discoveries we are forced to the conclusion that the practice of homœopathy is not limited to the avowed members of a distinctive school of medicine, but that the little "leaven" has at last leavened the whole lump; and we find the world of medicine practicing homœopathy; and although appeal may frequently be made to antipathy, to allopathy, to psycho-therapy, to electro-therapy, or to mechanotherapy in its various forms, yet the general practitioners of all schools now resort more frequently to the relationship of similars for curative results than to any other therapeutic method.

What a great day this would have been for the prince of medical reformers, the philosopher who truly said that the mild power is great!

It is true, the gropers in the dark practice a rather crude homœopathy; but it is homœopathy of a kind, nevertheless, and is a step in the direction which if followed can but lead to the light of day.

As already said, homœopathy was never more alive than it is today, for without the intention or the knowledge of its foes they have been turned into its advocates, and we have lived to see that for which our sages of old toiled and fought, for now as the might of right has crushed to earth the savagery and bestiality of belated feudalism, so the might of illiberal ignorance in medicine has been overcome by the mild but irresistible power of simple truth, and homœopathy has at last become the dominant therapeutic method of the present.



**DISTURBED METABOLIC BALANCE IN INFANCY.**

BY

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(Read before the Germantown Homœopathic Medical Society.)

DISTURBED metabolic balance, also known as weight disturbance, or fat constipation, is one of a group of nutritional disturbances or food injuries met with in infancy, whose etiology factor or factors may be summed up as an "overstepping of the infant's food tolerance."

It is seen almost exclusively in the artificially fed, though with not such frequency as formerly when cream and top milk mixtures were so much in vogue.

Clinically, it is characterized by pallor, irritability, restlessness, disturbed sleep, constipation with soap stools and stationary weight.

The chief offending element or constituent of milk in the causation of this condition is the fat. The intolerance produced may be due to a relatively high fat content in the food, or to a lessened food tolerance either from a congenital idiosyncrasy to milk or as a result of some intercurrent infection or disease. The principal fact to bear in mind in the recognition of disturbed metabolic balance is, that the amount of fat in the food need not be necessarily large, but it is present in amounts above the tolerance of the infant for milk fat.

The usual history is one of an infant who, after a period of rapid progress and growth, ceases or fails to gain in weight, notwithstanding the fact that it is being fed upon large amounts of food or upon milk mixtures which are theoretically correct; preceding or accompanying this is constipation with more or less peevishness and irritability.

Upon examination one finds a rather fat infant with soft flabby muscles and a varying degree of pallor to the skin.

Sleep, as a rule, is disturbed and restless, the infant awakening at the slightest noise or provocation. The temperature usually remains within normal limits, or at the most varying only a fraction of a degree either way.

Vomiting may or may not be present, but if so is usually confined to regurgitation of small quantities of milk, curdled or

otherwise. The abdomen is tympanitic and eructations of gas are quite frequent and common.

The most marked symptom of this condition is the constipation. The stools are hard and dry, of white or gray color, very foul smelling; of alkaline reaction, do not adhere to the napkins, and consist largely of insoluble soap. These fat-soap stools are not the result of a fat indigestion; but, rather, that of a disturbed salt metabolism through a relative over-feeding of fat. The excess is not absorbed, but remains in the intestinal tract, where it is saponified through the action of the alkaline intestinal fluids upon the fatty cells, resulting in the formation of insoluble calcium and magnesium soap stools. In consequence of this increased alkali demand there is a drain imposed upon the alkaline bases of the body which, disturbing the acid-alkali ratio or equilibrium gives rise to a relative acidosis, as evidenced by an excess of ammonia in the urine.

In many cases the weight curve is quite characteristic. At first there is a rapid gain in weight, often as much as 8 to 12 ounces weekly, which may extend over a period of a few weeks; at the end of which time the weight remains or becomes stationary, and any attempt to increase it, by increasing the food, results in a "paradoxical reaction;" an aggravation of the condition with additional weight loss, while diminishing or reducing the food causes a return to normal or a gain in weight.

Quite a few of these cases, particularly those showing a lessened food tolerance, are associated with the "exudative diathesis;" a condition first described by Czerny, manifesting itself in catarrhal inflammation of the mucous membranes, glandular enlargements and a tendency to such skin conditions as seborrhoea, eczema and intertrigo.

DIAGNOSIS.—The diagnosis is based upon the pallor and fretfulness, a feeding history of sufficient caloric intake with a relative excess of fat, a rapid gain in weight which becomes stationary, a high ammoniacal content of the urine and constipation. The chief difficulty lies in the tendency to regard disturbed metabolic balance as intimately associated with large amounts of fat in the food. Though this is frequently the case, as stated before, the condition does not depend so much upon the quantity of fat as upon the inability of the infant to utilize it without causing some nutritional disturbance.

PROGNOSIS.—The prognosis in uncomplicated cases with

a properly instituted diet is very favorable. As a rule 2 or 3 weeks are required to overcome the constipation and induce a gain in weight. In more severe cases, however, it may take months of careful attention to restore the infant to normal.

COMPLICATIONS.—One characteristic of these infants is their decidedly lowered resistance, in consequence of which infections of the naso-pharynx, lungs, middle ear and genito-urinary tract are frequent complications.

SEQUELAE.—Disturbed metabolic balance is oftentimes a forerunner of more serious nutritional disorders, such as dyspepsia and decomposition or atrophy. Chronic constipation frequently results from atony of the intestinal and abdominal muscles. Contrary to the general belief rickets is a frequent sequela.

TREATMENT.—The treatment of this condition is largely dietary. It consists in reducing the amount of fat and replacing it with some other food; for this purpose the carbohydrates offer the only satisfactory substitute.

In milder cases the simple reduction of the quantity of whole milk and the addition of carbo-hydrates in the form of sugar and starch is all that is required. In the more severe types fat-free milk, as found in skimmed or buttermilk, should replace the whole milk or cream; when necessary to do this, it is advisable to determine the fat tolerance as soon as possible by substituting 1 or 2 ounces of whole milk for the same amount of skimmed or buttermilk. If this is found to agree, the fat is gradually increased by the substitution of 1 or 2 ounces of whole milk every second day until the point of tolerance is reached. With the appearance of curds or chalky particles in the stools the fat should again be reduced to its former amount.

The one carbohydrate which seems to give the most satisfactory results in these cases is malt sugar. While the carbo-hydrate tolerance is high in this condition, it is well in giving them, especially the sugar, to make progress slowly for fear of causing a dyspepsia.

In more severe cases, because of its greater activity in overcoming constipation, malt extract may be used in the beginning in place of malt sugar, starting with about  $\frac{1}{2}$  oz. in 24 hours, and cautiously increasing one dram at a time until 1 or  $1\frac{1}{2}$  ozs. is given. After a few days malt sugar may be gradually substituted for the extract.



Malt soup is particularly good and exceedingly valuable in disturbed metabolic balance; the best results being obtained in infants from 3 to 6 months of age. Under the administration of malt soup the stools soon become pasty and of a mahogany brown color. In infants over 6 months of age, brilliant results oftentimes follow the use of a limited quantity of boiled or citrated milk, with the addition of toast, zwieback, rusk and cooked cereals, in increasing quantities until a steady gain of 6 to 8 ozs. weekly is obtained. To this diet broths or vegetable soup and orange or prune juice may be added.

Additional carbo-hydrates in the form of starch may be employed by replacing the water used as the diluent with cereal water made from barley, oatmeal or arrow-root.

HYGIENIC.—These infants, because of their marked susceptibility to respiratory infections, should have plenty of fresh air. The skin, too, should be kept clean, especially in the folds and the napkins should be changed as soon as wet or soiled. Great care, also, should be taken to avoid contact with infectious diseases of any sort.

MEDICINAL.—Any attempt to relieve the constipation by the use of drastic drugs, which at best is only temporary, is to be condemned. If, after a proper diet has been prescribed, the bowels do not move satisfactorily, suppositories may be employed, being careful to introduce them at the same time each day, with the object of training the bowel to regularity. When suppositories are not effective, simple enemas may be given for a few days. To the food may be added orange and prune juice or the syrup from figs. If drugs must be used, milk of magnesia in  $\frac{1}{2}$  to 1 dram doses, or various combinations of senna may give relief.

Homœopathically such remedies as calc-carb. and phos., graph., hepar, phos., silicea, and sulphur suggests themselves.

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THE DIGESTIBILITY OF CHICKEN SKIN.—Kohman and Shonle (*Jour. Bio. Chem.*, April, 1920, p 469) in the course of other experiments recovered a considerable quantity of chicken skin, with which they fed individuals. They found in a carefully controlled study, that when "65.1 to 67.5 per cent. of the nitrogen of the diet was supplied by chicken skin there was as good utilization of the nitrogen as when the same proportion of the nitrogen was supplied by meat, eggs, and milk."

**THE PRESENT STATUS OF ANTI-SERA.**

BY

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(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 18, 1919.)

THERE are being used at the present time quite a number of specific sera. Diphtheria antitoxin, tetanus antitoxin, anti-meningococcus, antistreptococcus and antopneumococcus serum, the less used dysentary and botulinus (sausage, olives, etc., poisoning) antisera, and finally, the antivenins. Incidentally, has sprung into practice the use of human immune serum more particularly against poliomyelitis, scarlet fever and the influenzal pneumonias.

Some of these antisera have not only their therapeutic value, but have a decided use in preventive medicine. For instance, the temporary immunization with diphtheria antitoxin or the more lasting immunization when employed with its specific toxin.

In the introduction of serum into the human system various methods are employed, intraspinous, intercutaneous, intramuscular and intravenous routes, together with the occasional introduction into the joints, pleura, cerebral ventricles and even the vitreous of the eye. These methods are employed for therapeutic purposes, except perhaps the cutaneous and intracutaneous methods which are mostly diagnostic.

The intravenous route one might almost say should be the only therapeutic route, except when the mechanical conditions are such, or where fear of an anaphylactic shock or other conditions suggest some other means for administration.

In the use of sera one introduces into the system a foreign protein and the body is bound to react. The result being anything from a slight febrile response to even death, in one who is particularly sensitive; but there are methods for detecting such sensitiveness and by proper desensitization, such a calamity can be averted. Interrogation of the patient as to any former treatment with serum, or if there exists any susceptibility to particular protein (food, polen, etc.), asthma.

After an experience of several hundred injections before one should employ them he must first familiarize himself not

only with the mechanical details but more particularly with their local and general manifestations.

In diphtheria and the prevention of tetanus the results of sera are familiar to all.

In meningococcus meningitis one recalls that in the pre-serum days 70 to 90 per cent. died. Serum, properly employed, today saves 70 to 80 per cent. In type one pneumonia, 30 to 40 out of every 100 died; today only 5 per cent. succumb; and lastly, one must not forget that in these diseases the sequelae, if they did not kill, very often left the patient an invalid. These complications can, for the most part, be prevented. In the diseases mentioned, we hold that the employment of specific sera, in competent hands, after proper tests for sensitiveness, and after proper desensitizing, and given early, in large and repeated doses, offers today the best means for combatting certain types of specific infections and its administration under the above conditions is without appreciable danger.

Several antisera, of which we may hear more about, I will just mention.

Anti-gasgangrene: The war stopped just about the time we were beginning to demonstrate its value, though industrial injuries may still find use for it.

The serum therapy of tuberculosis and typhoid fever has yet to demonstrate its value, the same may be said of the sera used against specific vegetable proteins, *e. g.*, the hay-fever group.

In anthrax serum used locally, injected in amounts of 10 to 15 c.c. around the pustule gives favorable promise in that condition.

The most disappointing is anti-streptococcus serum, but that condition will probably be overcome when bacteriologists have better isolated the many strains of streptococci, when more specific sera may be prepared against the specific streptococcus infection.

Keys has prepared a polyvalent anti-pneumococcus serum which has come into prominence. Its advantage is its small dosage, 2.5 c.c. Sera to be efficacious must usually be used in large doses, up to 100 c.c., and it is from this very fact that we get the most of our anaphylactic phenomena.

All are familiar with the late manifestations occurring seven or eight days following the use of serum, usually with the rash and troublesome itching. These later reactions where



any appreciable amount is used are rather constant, but the early manifestations of serum sensitiveness, that which may occur anywhere from one minute to three or four hours following the injection are the real alarming types, but can usually be prevented, first, by proper tests for sensitiveness; secondly, by proper desensitization, and lastly, by proper dilution and slowness in injecting the warm serum. If these details are carried out one can feel safe in administering a therapeutic agent which we feel today offers the best medium for combatting certain infections, and furthermore whatever reaction occurs regardless of the antisera used, it is never dependent on the antibody content of that serum, but is rather the result of the body's reaction to a foreign protein, usually horse serum, and if this element can be removed we will probably have begun a system of treatment for some disease that will be second to none.

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THE RESULTS OF OPERATIONS FOR CHRONIC APPENDICITIS: A STUDY OF 555 CASES—Gibson has made a careful and painstaking review of all cases of chronic appendicitis operated in the ward service of the First Surgical Division of the New York Hospital, January 1, 1913 to July 1, 1919. His study was to demonstrate how often the removal of a supposedly diseased appendix failed to relieve symptoms, and the reasons for and the methods of avoiding such failures. While it has long been recognized that an appendix is sometimes needlessly removed, it must be remembered that it is at times difficult to be certain that the appendix is not the seat of trouble and it is a fearful thing to tell a patient that he need not worry over his appendix and have him subsequently go through a severe acute operation and possibly die. Therefore a certain percentage of such operations will probably have to be performed for the sake of safety, but these should be reduced to a minimum.

The result in 102 cases were classed as unsatisfactory, but even in these cases the reports show that the 63% of them were safely and on the whole comfortably rid of a definitely bad appendix, which is by no means a surgical failure.

To avoid disappointing results after operations for chronic appendicitis the author recommends: 1. A comprehensive and detailed history. 2. A complete and thorough physical examination, including all refinements of diagnosis. 3. Exercise caution in undertaking operation on women as compared to men. 4. Exercise caution with the more mature patients, particularly women. In this class other lesions may coexist or may be mistaken for appendicitis. 5. Avoid the neurasthenics of any age or sex. 6. Exercise particular restraint when there is no clear and reliable history of well-defined attacks, particularly of localized pain accompanied by nausea or vomiting. 7. Make a good sized incision, and even if a frankly pathological appendix is found, look for other possible lesions. 8. If no obviously pathological appendix is found, do not cease looking for other lesions until every other possibility has been exhausted; make a supplementary incision if necessary. —*Amer. Jour. Med. Sciences*, May, 1920.

## EDITORIAL

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### THE ETIOLOGICAL RELATIONSHIP OF PROTEIN POISON TO FEVER.

CONTINUED fever without demonstrable cause is quite common in children and, therefore, any research work which tends to throw light upon the subject of obscure fevers is gladly welcomed by the pediatricist. Before, however, considering a fever as idiopathic we must be absolutely certain that we are not dealing with a case of tubercular infection or with an encysted empyema.

Alimentary toxemia and iliac stasis are more prone to induce fever in childhood than in adults. Under the heading of an alimentary toxemia we must include cases of helminthiasis; there is no doubt that the excretions from ascarides or toxic products resulting from their decomposition in the intestinal tract may be a cause of fever. The fact that we usually have a well developed eosinophilia in cases of intestinal parasites proves conclusively that they excrete in some way a protein substance foreign to the host and capable of inducing this blood reaction.

The chief role of proteins in fever, however, depends upon the presence in every protein molecule of a toxic radicle, or protein poison which is capable of setting up a febrile reaction and of inducing the symptoms of toxemia whenever this toxic substance is liberated in the system and consequently absorbed. Vaughn has shown that during the process of digestion proteins become poisonous at about the peptone stage and if the peptone formed in the alimentary canal be absorbed as such and enter the circulation it is capable of acting injuriously. Proteins may, however, also be digested parenterally and the protein poison thus be set free directly in the blood stream. This is well illustrated in the case of infection with the typhoid bacillus. During the first ten days of the infection there are no symptoms; the bacilli grow rapidly in the body but are incapable of inducing fever. At the end of this time, however, the body-cells have poured out sufficient ferment to destroy the invading organism, which has simply acted as any other foreign protein finding its way into the blood stream, the bacilli are digested and the toxic protein is

liberated. With the liberation and absorption of this toxic substance the symptoms of the disease, namely fever and toxemia, make their appearance. It is, therefore, not the bacteria, *per se*, but the foreign protein which they represent, that is responsible for the febrile phenomena.

The discovery of the protein poison and the knowledge of how it can be liberated from apparently harmless protein substances by means of parenteral digestion has given us a rational explanation of many cases of obscure fever and other toxic manifestations of similarly obscure origin. A celebrated clinician once said that all continued fevers encountered in this part of the world were either due to tuberculosis, typhoid fever or sepsis. Perhaps he was right in the majority of instances; however, the possibility of a fever of other than bacterial origin is not to be denied.

C. S. R.

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#### THE COMMUNITY LABORATORY.

It may be because much surgery is of an emergency nature, that in nearly every community may be found physicians who practice surgery. It should be so, to care for those who are so unfortunate as to meet with accidents, or be stricken with acute appendicitis or strangulated hernia, for example. On the other hand, it not infrequently happens that a skilled internist in such localities, is a rarity. The general nature of medical cases along with the limited supply of material, prevents the rural or smaller-town practitioner from perfecting himself to the degree that he may pose as an internist, as his brother does a surgeon.

In no branch of our art does the clinical laboratory shine as it does in internal medicine. Recognizing an "acute abdomen," the surgeon is justified in operating; be the condition due to appendiceal abscess, ectopic gestation, bowel obstruction, or a suppurating gall-bladder. It requires much study to differentiate some cases of typhoid and acute tuberculosis, and it is in such cases as these that the laboratory tests are most valuable, to say nothing of their importance in the host of vague medical diseases which are only too common and unrecognized.

Since many of the physicians in smaller communities real-



ize their handicap, and since these same men meet on common ground to discuss cases or otherwise mutually benefit; it occurs to us that were they to subscribe as a body to the services of someone, not a physician, trained in laboratory technique, they would aid both themselves and their patients. Such a person could examine urine, blood, sputum, gastric contents and do the many varieties of bacteriological work. It would remain, however, for the medical mind to interpret the findings.

The cost of equipping a laboratory and maintaining at a salary, such a community technician, would be small compared with the good it would do. Ten physicians with a moderate practice each, could furnish enough work to such a laboratory, and the nominal excess fee charged to the patients, would enable the laboratory to be self-supporting. Smaller groups of men could secure a nurse who has had a laboratory training and who could act as community technician and nurse, and we feel that their patients would not hesitate to pay a modest sum for such services.

In many office buildings of the large cities, laboratories may be found that are supported by physicians who have their offices in the building. These laboratories belong to no one physician in particular, but to all who by their patronage make these convenient necessities possible.

The public away from the large towns are deserving of all the medical care and attention which falls to the lot of the city dweller, and by establishing and maintaining such a community laboratory, physicians in the removed localities would do much toward giving their clientele all that modern medicine can give. It would further enhance the practice of internal medicine and keep, particularly the younger physicians, from settling in the large towns to specialize.

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### **SOME OLD AND NEGLECTED REMEDIES: III. GOLD (AURUM)**

At one time a popular remedy in our school, at present gold appears to be neglected excepting for its financial value. The various preparations currently used are the aurum metallicum, aurum muraticum, and aurum muraticum et natronatum. The physiological action of the drug is worked out in our own

material medicas and is published by Bartholow and others of the old school, suggesting strongly that the neglect of the remedy at the present day is not at all justified. The three pre-eminent spheres for therapeutic action include, first, mind; second, the kidneys, and third, late syphilis. Considering the mental affections to which it is applicable they relate mainly to melancholic states associated with self-condemnation, mental anguish, and suicidal disposition. These effects of the remedy have led to its use in melancholia hypochondria and depressed mental states generally.

Gold has also been shown to be capable of producing congestions of various organs and has accordingly been used with success in congestive headaches and vertigo. Hyporemia of the kidneys has been produced by it; the condition ultimately terminating in fatty degeneration, the urine becoming scanty and albuminous; in other instances it has produced the granular or cirrhotic kidney. These terminal effects being the result of circulatory changes would suggest the use of gold in the renal diseases occurring in conjunction with cardio-vascular diseases. Bartholow was always enthusiastic over the use of the double chloride of gold and sodium in doses equivalent to 1/20 of a grain in chronic interstitial nephritis. While perhaps his enthusiasm led him too far, there can be no question of the value of the remedy within certain limitations.

In cardiac affections it has proven a remedy of considerable value in hypertrophy with fatty degeneration, wandering pains sometimes with palpitation and irregular pulse, associated with hypochondriasis. Commonly, the condition is furthermore associated with pulmonary congestion, any slight exertion being likely to be attended by sensations as of crushing weight in the sternum. In the aurum cases of heart decompensation symptoms are often such as we find associated with aortic regurgitation; the patient experiences fullness of the head, head feels sore, depressed mental condition, roaring in the ears, flashes of light before the eyes, bloating of the face, and retinal congestion.

Prior to the discovery of the spirochete and of the value of the new arsenical preparations, gold enjoyed a wide-spread reputation in the treatment of late syphilis, especially in syphilis of the nervous system and of the bones. In the latter field it was quite extensively used for syphilitic ozena, especially if associated with ulceration. Other specific affections

for which it was used included diseases of the middle ear and mastoiditis, and syphilitic sore throat.

The above may be considered as merely suggestive of the use of gold in therapeutics, its full value can only be estimated by a study of our own pathogenises of the drug and reference to the old school authorities of the past: those of the present day apparently ignoring it entirely.

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### A NEW INTERPRETATION OF HYPERTHYROIDISM.

WE were induced to visit an exhibition of modern art. On the walls of the gallery were displayed many and wonderful colors, the atmosphere of the rooms was cubistic, futuristic and mystic. What might have been interpreted as a conflagration with a sky of impossible Nile blue, and flames of equally impossible red and yellow turned out to be nothing more than the "Birth of the Flag." Finally we discovered something we could understand, or what is equally satisfying, we thought we could. There it was true to life, the prominent eyes, the wide palpebral apertures, the staring facial expression, the prominence of the neck, and the vaso-motor relaxation, and we had before us an unquestionable example of hyperthyroidism. We approached with awe and reverence, indeed with respect for the perspicacity of an artist devoted to realism, and we read the title of the picture, "The Cry of the Soul." Artist and model betrayed the *motif pathologique*.

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DEXTROSE TOLERANCE IN ATROPHIC INFANTS.—P. M. Mattill, K. M. Mayer and L. W. Sauer, Chicago (*American Journal of Diseases of Children* January, 1920). Experiments were carried out by the authors to determine the glucose tolerance of atrophic infants with the idea in mind that such infants might derive some benefit from intravenous glucose injections. They summarize their findings as follows:

"1. The glucose tolerance of the approximately normal infant as determined by the Woodyatt method (utilizing an apparatus permitting of a continuous intravenous injection of solutions at any desired rate) is very likely identical with that of the normal adult which is 0.8 to 0.9 gm. per kilogram per hour.

2. The tolerance of atrophic infants for glucose is considerably greater; it varied in our cases from 1.4 or 1.5 gm. to 1.8 gm. per kilogram per hour."



## GLEANINGS

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### UROLOGY

Conducted by LEON T. ASHCRAFT, M.D.

**SURGICAL RENAL TUBERCULOSIS: THE PROGNOSIS.**—W. F. Braasch (*Am. Jour. Med. Sci.*, 1910, CLIX, 8) from his experience in a study of 532 cases operated on at the Mayo Clinic for renal tuberculosis during the last twenty years, concludes that the disease is most frequent between the ages of twenty and forty, and occurs in males nearly twice as frequently as in females, the postoperative mortality being a little higher in the former than in the latter. In childhood, renal tuberculosis is usually a part of a general tuberculosis, and is not a surgical condition. In about seventy-one per cent. of the cases, if not in more, there may be found evidences of the presence of this disease in other parts of the body, but the postoperative mortality among those with associated lesions is no higher than the general average. Unless they are a part of an active general infection, multiple lesions do not, of necessity, make the prognosis worse. In about one-third of the cases, there were evidences of healed pulmonary disease. In these cases, the percentage of recoveries was above the average, probably owing to the fact that these patients had increased powers of resistance. Active pulmonary lesions existed in about five per cent. of the cases, the percentage of recoveries among these after nephrectomy being more than sixty per cent.

In 73 per cent. of the males, involvement of the genitalia was present, but did not prevent ultimate recovery. Spontaneous healing having occurred so often in the prostate and seminal vesicles, the author does not approve of their removal at a subsequent operation. In six per cent. of the cases, tuberculous lesions of the bones and joints existed. One-half of these lesions were active. The late mortality was five per cent., and this led the author to conclude that the presence of such complications may show increased resistance. In 5.7 per cent. of the cases, spondylitis, usually healed, was found, the mortality in these cases being 12 per cent.

The author believes that chronic spondylitis does not affect the prognosis. Active spondylitis, however, while not contra-indicating nephrectomy, does not offer a favorable prognosis. Tuberculous adenitis existed in 6.4 per cent., the mortality in these nineteen patients being but ten per cent.; this suggested to the author a heightened resistance. He does not consider a reduction in the amount of hemoglobin as necessarily influencing the prognosis. When marked involvement of the bladder existed, the mortality was twice as high as among those with but slight involvement of that viscus. Braasch believes that the degree of involvement depends more upon the virulence of the infection than upon its duration. He found the mortality percentage to be markedly affected by the amount of pathologic involvement of the kidney, early lesions showing the lowest mortality, and pyelonephrosis the highest. He considers occluded renal tuberculosis to be indicative of relative immunity, producing a low mortality. He has not found that the duration of pre-operative symptoms affects materially the late mortality. He thinks that recovery from bladder symptoms is more likely to take place, and to take place earlier, if the pre-operative symptoms are of short duration than if they have been present for a long time. In cases of bilateral tuberculosis of the

kidney, neither recovery nor permanent improvement of the remaining kidney can be expected to follow the removal of one other organ. He advises operation in cases of bilateral renal tuberculosis only when there are acute unilateral complications, with no prospect of ultimate recovery. He has found late mortality to be highest during the first year, and to decrease with the lapse of time following the surgical procedure. He considers the operative mortality a negligible factor, but states that the late mortality (up to five years after the operation) is in the neighborhood of twenty per cent. Failure to obtain a complete cure occurs in approximately twenty per cent. of the cases. In the other eighty per cent. the prognosis is good for recovery; and a complete cure may be expected in sixty per cent.

**TWO UNUSUAL CASES OF PYELONEPHRITIS.**—P. W. Aschner (*Jour. Am. Med. Ass'n.*, 1920, LXXIV, 320) believes that no hard and fast rule can be laid down in regard to the indications for surgical interference in cases of pyelonephritis. He considers the reaction of the body to the infecting organism of as much importance as the type of bacteria causing the infection. When there is evidence of severe septic absorption or renal insufficiency with nitrogen retention, he believes that primary nephrectomy to be the safer procedure; also when the illness has lasted for a considerable length of time, so that the patient has lost a good deal in weight and strength. The main features of the first case were the sudden appearance of a virulent infection, brought about by an indwelling catheter; a great many concretions in a prostatic adenoma; renal infection in an organ with a bifid ureter and double pelvis; uremia, the result of unilateral pyelonephritis, and disappearing at once after the removal of the diseased kidney; and nephrectomy, with a good functional result. In the second case, the bacillus coli was present in the bladder urine, but not in the ureteral urine. Urine removed from the right ureter just previous to operation showed, on culture, "anhemolytic streptococci;" but this was not known until a nephrotomy had been done, a phosphatic stone being removed. A week after this, as the patient did not improve, the kidney was removed; but at the end of three days death followed from peritonitis, seemingly of metastatic origin. The author believes that a primary nephrectomy might have saved this patient.

**CYSTORADIOGRAPHY.**—F. Legueu and E. Papin (*Presse med., Par.*, 1919, XXVII, 733) consider this method of diagnosis absolutely necessary in cases of diverticula. They take a picture of the bladder after it has been filled with an opaque solution, and another after it has been emptied. If a diverticulum is present, it will show in the latter picture, because it will not be evacuated with the bladder. Large and medium sized tumors, especially when cystoscopy is prevented by constant hemorrhage or intense cystitis, should also be examined radiographically; also neoplasms that can be only partially seen by means of the cystoscope. Very good results have been secured by the use of the X-ray for the detection of vesical calculi after inflating the bladder with air or oxygen. Cystoradiography is also of use in the diagnosis of vesical malformations, but is of little value in cases of hypertrophy of the prostate.

**RECURRENT NEPHROLITHIASIS.**—O. F. Lamson (*Annals of Surgery*, 1920, LXXI, 16) thinks that the etiology in such cases is the same as in cases of primary stone formation, and that some of these etiological factors might

be removed at the time of operation. Some factors tending to prevent recurrence are—an accurate preoperative diagnosis as to the locality and size of the stone; an operation that does not injure the pelvis of the kidney or the ureter, thus producing a stricture; and an incision large enough to allow the surgeon to lift out the whole stone readily. The author considers further knowledge concerning the true etiology of nephrolithiasis essential, if one hopes to prevent its recurrence. In order to determine the best postoperative measures to employ, one should make a careful study of the patient's history, a thorough examination of the urine, and a chemical analysis of the stone. Having the patient drink large quantities of water, preferably distilled water, the author thinks may aid in dislodging and removing any possible nucleus for future stone-formation. This should be persisted in for a long time after the urine has completely cleared up. If fragments of stones are left in the pelvis at the time of operation, they may cause a recurrence of the condition.

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## OPHTHALMOLOGY

Conducted by WM. M. HILLEGAS, M.D.

PARALYSIS OF ACCOMMODATION DUE TO FOCAL INFECTIONS.—At the June 1919 meeting of the American Ophthalmological Society, Dr. Clarence A. Veasey of Spokane, Washington, reported three additional cases of paralysis of accommodation, due to focal infection, two resulting from diseased tonsils, and one from an alveolar pus pocket; all three cases resulting in complete relief of the inability to read, after removal of the infected focus. He suggested that in many cases of subnormal accommodation or accommodation asthenopia, not deeply affected as in the cases of paresis or paralysis of accommodation, there must frequently be found these foci of infection in the tonsils or teeth, in addition to the better known cases, caused by some pressure within the nose, with or without sinus infection.—*American Journal of Ophthalm.*, Vol. 2.

SYPHILIS.—Schurmann finds that in spite of the general interest in the question of hereditary syphilitic eye diseases in the second generation, the question is not solved and two opposite viewpoints are sharply contrasted. According to Finger this inheritance is possible in three ways: first, as a manifest lues; second, as a toxic, syphilitic dystrophy; and third, as an absolute immunity. A case to be positive must fulfil the following three postulates: The lues of the first generation must be proved to be hereditary, an acquired form must be excluded, and lastly, the lues of the second generation also must be proved to be not acquired.

It is very difficult to meet these demands; especially difficult to exclude an acquired lues of the first generation, and the reinfection of hereditary luetics is of great importance. Fournier mentions a number of such cases, but many of them are not without objection as they are composed of dystrophies which in many cases are certainly not absolutely indicative of lues. The author examined children of hereditary luetics. It was remarkable how many of such unions remain sterile. Thirty-six children of seventeen families were examined. A general pediatric examination, then that of the eye and ear, an X-ray of the epiphyses of the knee and foot joints, and the Wassermann reaction. The examination disclosed the complete absence of all signs in these children that might have been interpreted as being due to hereditary lues.—*American Journal of Ophthalm.*, Vol. 2.



**TUBERCULOSIS.**—Fernandez points out that because of its insidious onset tuberculosis is likely to escape recognition. Its ocular manifestations are generally secondary; but rarely secondary to pulmonary tuberculosis. An eye affection distinctly chronic in its course is open to suspicion. He finds tuberculin treatment his main reliance.

Weeks holds that to establish a diagnosis of tuberculosis in the eye the subcutaneous injection of old tuberculin is generally considered best. He begins with 1 mg. in the adult, and one-half that amount in children, repeating the dose in 48 to 72 hours, if no reaction is produced, using 2 mg. for the second and 3 mg. for the third dose. The focal reaction so produced is increase of hyperemia of the conjunctiva, the appearance of an exacerbation in iritis with haziness of the aqueous. In choroidal disease the haziness over the affected area is increased, and vision may be further impaired. The same is true of lesions of the retina or optic nerve. The reaction may last from 6 to 48 hours, and usually leaves the eye better when it subsides. For therapeutic purposes other tuberculins may be employed. He prefers a dose just short of that sufficient to produce a systemic reaction. The range of doses is very wide, 1-250,000 mg. has produced a strong reaction, while 3 mg. has been given without any appreciable constitutional effects. He continues the injections at least two months after all signs of activity of the focus has subsided.

For the diagnostic use of tuberculin Peter considers only the cutaneous and the subcutaneous tests; and for himself has abandoned all but the latter. He gives old tuberculin the rank of the best preparation for this purpose, and holds the focal reaction to be the most convincing evidence. He believes that the negative result obtained in some cases depends on the absence of some special toxin ingredient, and a variation of the preparation may give better results. For therapeutic use he places the initial dose at 1-10,000 mg., for either adults or children, and if this gives a marked reaction the dose must be diminished. The necessity for using small doses to avoid a febrile reaction and continuance of the treatment over long periods is emphasized by Gardini. He too begins with an initial dose of 1-10,000 mg.

Torok points out that the conjunctival test has been absolutely abandoned. The cutaneous reaction only indicates the presence of a focus in the body, and possesses large elements of danger. The subcutaneous method has been absolutely void of danger in an experience of 1,000 injections; and yields focal and general as well as a local reaction. He reports the statistics of 100 cases. His method is to begin with 1-10,000 mg., increasing the therapeutic doses an equal amount with each administration, until it reaches 1-100 mg., then increasing by that amount until 1-10 is reached, and by 1-10 up to the maximum dose of 1 mg. The duration of treatment must be long.—*American Journal of Ophthalm.*, Vol. 2.

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## MEDICINE

Conducted by CLARENCE BARTLETT, M.D.

**EARLY LESIONS IN THE GALLBLADDER.**—Mac Carty and Corkery have investigated this very important subject. Their observations show that in but few instances so far as the Mayo Clinic is concerned, does a case reach operation at what might be called an early period. Of 4,998 gallbladders removed, 4822 or 96.5 per cent. showed gross pathological lesions. The stated remainder, 157 cases revealed the following lesions: 1. Congestion

and edema of the villi frequently associated with a bulbous appearance which, on casual gross examination, makes the villi appear cystic. 2. Local or general slight degree of lymphocytic infiltration which manifests itself only in a slight enlargement of the villi and a cloudy or duller appearance. 3. Local or general slight degree of lymphocytic infiltration is seen in the mucosa alone, which might possibly be considered normal, since the mucosa probably contains a certain number of lymphocytes; but when seen in association with a lymphocytic infiltration in the submucosa, muscularis and subserosa very probably indicates a pathological condition.—*American Journal of the Medical Sciences*, May, 1920.

**GASTRIC SECRETIONS IN NEUROCIRCULATORY ASTHENIA.**—Musser said of this subject, based upon observations in the United States Service: "In patients suffering with neurocirculatory asthenia there is a very definite increase in the total acidity and free hydrochloric acid as compared with controls. These figures do not represent abnormal hyperacidity. As Reh fuss has shown that the usual conception of hyperacidity is erroneous, an apparently normal acidity of over 100 is common. They do show, however, that almost uniformly soldiers suffering with neurocirculatory asthenia as contrasted with apparently normal soldiers, both eating the same food, under identical routine and under the same conditions of living, show a higher gastric acidity. This is a diagnostic point which may be of value in differentiating the disorder in questionable cases. It surely seems to add further evidence to that already accumulated that these soldiers are suffering from a neurosis with which is probably associated a hyperirritable vagus."—*Amer. Journal of the Medical Sciences*, May, 1920.

**INFLUENZA AND TUBERCULOSIS.**—Anderson and Burns supplement a previous communication on epidemic influenza among patients and employes of the Loomis Sanatorium, Loomis, New York, with a further analysis of the histories of patients who had influenza before entering the sanatorium and a record of the incidence and fatality of this disease among former patients. They also give a critical review of recent literature on the subject.

Of 1227 traced former patients, 70 contracted influenza and 16 (22.9 per cent.) died of the disease. Of 199 new patients admitted between November 1, 1918, and November 1, 1919, 42 or 21.1 per cent. gave a definite history of influenza. Of these 42, 18 knew they had tuberculosis prior to their influenza, while 26 gave a history of previous symptoms that were presumably tuberculous. In 12 cases the onset of tuberculosis was definitely post-influenzal.

The authors conclude that tuberculosis does not confer an immunity to influenza; that influenza is not less severe among the tuberculous; that among their own patients the case fatality was higher than among the general population; that among a certain number of individuals influenza marks the inception of pulmonary tuberculosis; and that to ignore or deny the possibility of pulmonary tuberculosis as a sequela is to unduly defer diagnosis and early treatment.—*American Review of Tuberculosis*, April, 1920, vol. IV, No. 2.

**ACTION OF THE ULTRAVIOLET LIGHT ON THE INTRADERMIC TUBERCULIN REACTION.**—In studying the action of the ultraviolet light, Edgar Mayer of Saranac Lake performed experiments as follows: (1) Tuberculous guinea

pigs were exposed to the light and then given intradermic tests; (2) tuberculous guinea pigs were given tests and then exposed to the light; (3) old tuberculin that had been exposed to the light was used for intradermic tests on tuberculous guinea pigs; and (4) tuberculous patients were given skin tests both before and after exposure to the light, while some were tested with tuberculin that had been exposed. Mayer finds that exposure of the skin to the light, both before and after the intradermic test, tends to blunt the skin reaction to tuberculin; and that tuberculin exposed to the light loses some of its capacity to produce reactions.—*American Review of Tuberculosis*, April, 1920, vol. IV, No. 2.

## DERMATOLOGY

Conducted by RALPH BERNSTEIN, M.D.

**LOSS OF HAIR DUE TO LIGHTNING.**—According to T. Ashby, during a thunder-storm in October, 1918, a house was struck by lightning and badly damaged. Three children, a girl of 9 years and two boys, aged 7 and 5 years, were in the same bed on the first floor. According to the statement made by the mother, the children were all lying with their heads up at the same end of the bed, and all were asleep on their right side, in accordance with their usual custom. The children were naturally frightened by the thunder and lightning, but were not harmed when the bolt struck the dwelling. About two weeks later the hair on the left side of their heads from the middle line downward began to come out, and in a few days the scalp on the left side of their heads was quite denuded of hair. The right side of their heads was protected from the lightning by the pillow. After a period of three months, the hair was found to be slowly growing again, and each of the children was in good health. The lightning seems to have had a direct effect on the hair follicles similar to that of the X-rays.—*Brit. Med. Jour.*

**FREQUENCY OF SEBORRHOEA AND ABSENCE OF ALOPECIA IN ALGIERS.**—Seborrhoea of the scalp has long been recognized as a cause of alopecia of the vertex. Montpellier has made a careful study of the scalps of Algerian natives and has found that seborrhoea of the scalp is quite frequent, in fact, as frequently encountered as it is among Europeans. The natives are very uncleanly, and, moreover, they wear the heavy head-dress peculiar to Algerians, and it would seem that if seborrhea and hats are a cause of baldness, one should encounter alopecia very frequently among the Algerians, but on the contrary, baldness is extremely rare among the natives.—*Bull. Soc. franc. de dermat. et de syph.*

**LICHEN PLANUS IN PRIVATE PRACTICE.**—Charles J. White, after a clinical study of 64 cases, submits the following findings: Lichen planus is a subacute and at times an acute disease. The educated classes and especially those whose immediate past has been troubled seem to be the most susceptible. Sometimes it follows an injury. It seems to occur more often in women than in men. It appears largely in the fourth and fifth decades of life. It varies greatly in duration—some cases come and go in a few weeks; many last months; some may persist for years. The flexor surface of the wrists may be the site of predilection of the initial lesions, but they may and do appear on almost any part of the body, and even on the mucous membranes where the characteristic violet coloration becomes silvery white. The final



distribution of the eruption may be universal. White describes the typical objective lesion as an almost pathognomonic papule, but many variations occur. The disease is always pruritic, and the suffering is at times almost unbearable. Treatment is palliative and a cure seems to depend largely on natural evolution.—*Journ. Cutan. Dis.*

**DILATATION OF THE COLON IN CHILDREN.**—Alfred Edward Meyers. This condition shows a characteristic past history. A bowel movement without the aid of a suppository, enema or laxative is a rare occurrence. Distention with gas and abdominal protuberance are noticeable. Normal growth is interfered with, the patient is below par and the resistance to infectious diseases is lowered. The diet is usually made up largely of carbohydrates, the starchy elements predominating. Roentgenograms show a great increase in the diameter of the colon and a thickening of its walls and also a looped, twisted, redundant, dilated and hypertrophied sigmoid.

The consensus of opinion seems to be that dilatation of the colon is a congenital abnormality in the lower end of the hind gut, which takes the form of a muscular hyperplasia. It usually involves the rectum and spreads a varying distance up the colon. The author believes that there is still another element concerned in this condition, that of *spasm*. The similarity between megacolon and hypertrophic pyloric stenosis is brought out because there are present in both conditions hypertrophy, hypertrophy of circular muscle, dilatation, visible peristalsis, constipation, congenital malformation, gastro-intestinal retention and probably spasm.

In treating dilatation of the colon, the patient is put upon a starch-free diet but including fruit juices and is given 5 drops of atropin sulphate solution, each drop containing 1-1000 grain, three times daily, the dose being increased one drop daily until the child complains of dryness of the mouth. Gradually, well done toast, cooked fruit and green vegetables are added to the diet and the atropin is decreased. The constipation ceases after the spasm is relieved and normal defecation follows.—*American Journal Diseases of Children*, March, 1920.

**LICHEN PLANUS IN TWO BROTHERS.**—The occurrence of two cases of lichen planus in one family is a rare thing and worthy of note. Montgomery and Culver report having observed two brothers, one of whom was forty and the other thirty years of age, with lichen planus. The disease appeared first in the elder brother, ran a characteristic course and finally yielded to treatment. About two years later the younger brother presented himself for treatment. Both men were found to have marked disturbances of the gastro-intestinal tract. The older brother was a rancher, and the younger a druggist. They lived in widely separated communities.

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## SURGERY

Conducted by J. D. ELLIOTT, M.D.

**NEWER CONCEPTIONS OF THE PATHOGENESIS AND TREATMENT OF EMPYEMA.**—Moschocowitz in the Mütter Lecture before the College of Surgeons of Philadelphia discussed his views of empyema very thoroughly. The pathology and the methods of treatment found to be most useful at several large military hospitals formed the basis of the experience upon which the author's views were founded. His conclusions were: 1. Empyema in most

instances results from the rupture of a small sub-pleural pulmonary abscess. 2. An empyema is the final stage of a process in which the first stage is a serous pleurisy and the second a seropurulent pleurisy. The latter is the so-called "formative" stage of an empyema. 3. The "formative" stage is unaccompanied by pleural adhesions. The stage of final empyema is always accompanied by adhesions. 4. The vast majority of empyemata are of the encapsulated variety. Very few occupy the entire pleural space. 5. Metastatic suppurations accompanying empyema are to be found rather as complications of the causative pneumonia than of the empyema. 6. The treatment of an empyema should be begun in the formative stage before the exudate has been converted into frank pus. 7. It is unwise to perform an operation in the formative stage. The mortality is terrific because the accompanying pneumonia is still in full bloom, and furthermore, because of the absence of adhesions there occurs a pneumothorax with "fluttering of the mediastinum" and consequent embarrassment of the heart action. 8. The best surgical procedure in the formative stage is repeated aspirations, done every twelve to twenty-four hours, in order to relieve the respiratory embarrassment due to the mechanical pressure of the rapidly accumulating fluid. In a few cases this measure is curative. 9. Feeding with a diet rich in calories is an important adjuvant in the treatment of the formative stage. 10. The treatment in the acute stage of an empyema consists in a simple intercostal thoracotomy. This operation need not be considered an urgent one, and should be performed when the patient's condition is otherwise perfectly satisfactory. This is the so-called "late" operation. 11. Urgent thoracotomy is indicated only in acute pyopneumothorax. 12. The Carrel-Dakin treatment, properly carried out, has proved of superlative value in the postoperative treatment of empyema and should be used in every case. There are no contra-indications to its use. 13. The mortality of acute empyema by these methods is lower than that reported by other methods of treatment. 14. Empyema cavities heal by three methods: (a) by the formation and absorption of a sterile exudate; (b) by the formation and "absorption" of a closed pneumothorax; (c) by the "classical" method, i. e., the expansion of the lung and the obliteration of the pleural cavity by adhesions. 15. Chronic empyema should not occur, or at least should become very rare, if the methods of treatment of acute empyema as formulated above are practised. 16. "Chronic" cases of empyema may be defined as such which are not amenable to treatment by the Carrel-Dakin method. 17. Recurrences in empyema are usually the result of undue haste. The percentages of recurrences is less after the Carrel-Dakin method of treatment than after any other. 18. The vast majority of operations that have been devised for chronic empyema will have a very limited field of usefulness if the methods of treatment advocated above are carried out.—*Amer. Jour. Med. Sciences*, May, 1920.

OPERATION AND REOPERATION FOR GALLSTONE DISEASE.—Deaver has found the three most frequent causes for recurrence of symptoms after gall-bladder operations (cholecystostomy or cholecystectomy) were: first, adhesions; second, new stone formation; and, finally, chronic cholecystitis. While ordinarily adhesions do not give rise to symptoms until they are mature and contract, Deaver has had several patients who developed obstruction of the duodenum or pylorus from this cause within one to two weeks after operation. Cholecystectomy, unless done with great gentleness and accuracy,

tends to set up more extensive and more dangerous adhesions than does cholecystotomy. The best method of treatment for such obstructions, either early or late, is usually a posterior gastro-enterostomy.

The author believes that with few exceptions the stones found at a second operation were probably present but overlooked at the primary operation. He points out that small granules of stones adherent to or imbedded in the mucous membrane of the bladder or ducts may subsequently develop into one or more good sized stones. He has frequently observed such fragments in gallbladders after their removal, or a calculus lodged high up may later descend into the common or hepatic duct and increase in size until it cannot be passed and thus cause obstruction. When a number of years have elapsed between operations it is probable that the stones are newly formed.

Recurrence of symptoms from the persistence of infection is inexcusable and its frequency lends support to the theory that non-calculous cholecystitis is a clinical entity distinct from calculous gallbladder inflammation, and justifies the removal of the gallbladder in such cases. Chronic cholecystitis can generally be recognized by a proper correlation of the history and the results of physical examination, especially local tenderness and more or less local rigidity. In cases of doubt the roentgen ray and various laboratory methods of examining the condition of the stomach, duodenum, pancreas, intestinal tract, etc., may be called upon.

While cholecystectomy is the operation of choice in cholecystitis, its difficulties and dangers are much greater than cholecystostomy, therefore drainage is the better procedure for the occasional operator.

Included in this paper was the report of Reimann of his investigations upon the streptococci as the etiologic bacteria of cholecystitis. Forty-five gallbladders were treated by the method of Rosenow and the streptococci, all of the *S. viridens* variety, were found in nine, or 20 per cent. of them. Other organisms were detected but no attention was given to them as the entire study was devoted to the streptococci. Efforts to produce gallbladder disease in rabbits by the intravenous injection of these germs were unsuccessful and the conclusion was reached that the particular streptococci recovered from human gallbladders showed no elective affinity for the gallbladders of the animals injected.—*Journ. A. M. A.*, April 17, 1920.

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## PEDIATRICS

Conducted by C. S. RAUE, M. D.

THE ATROPIN TREATMENT OF PYLOROSPASM AND PYLORIC STENOSIS.—Sidney V. Haas is a strong advocate of the atropin treatment of pyloric stenosis. Following is a summary of his paper on this subject:

"1. Hypertrophic pyloric stenosis is probably only an advanced degree of pylorospasm.

2. Both being manifestations in the syndrome of hypertonia (hypertonic infant).

3. The etiology is probably a disturbance in the physiologic action of the vegetative nervous system.

5. This does not gainsay the occasional existence of true organic stenosis of the pylorus.

6. Despite the brilliant results of many surgeons by the Rammstedt operation, in this condition an operation should be rarely required, and only



performed after atropin has been given a trial.

7. Atropin properly used has been regularly effective in producing a cure.

8. At the present time the weight of authority would seem to indicate that hypertrophic pyloric stenosis and pylorospasm are two definite clinical entities.

9. Among the arguments used against medical treatment is the sudden death, which not infrequently occurs. These are usually thymus deaths, and occur in cases operated as well as those medically treated.

10. Atropin is the logical treatment in these cases owing to its paralyzing effects upon the vagus nerve endings.

11. A common dose of atropin for an infant of this type from a few weeks to a few months of age is 1-50th to 1-25th of a grain in 24 hours, with an extreme of 1-16th of a grain divided among the day's feedings, a 1-1000 solution being used, beginning with one drop and increasing rapidly until effective.

12. The most frequent toxic symptoms are flushing, midriasis, dryness, which disappear promptly when the drug is withheld. There is no danger even when such symptoms present themselves."—*Archives of Pediatrics*, October, 1919.

DIAGNOSIS OF TUBERCULOUS MENINGITIS IN CHILDREN.—Rominger (*Munchner Med. Wochenschrift*, Nov., 1919) comments on the tendency to regard tuberculous meningitis as a distinct disease, whereas it is important to bear in mind that it is in reality only one aspect of general miliary tuberculosis, and that the condition of the other organs, especially the lungs, may offer valuable evidence for an early diagnosis. Although tuberculous meningitis is usually easily recognized if there are pronounced brain symptoms, yet in the beginning of the disease, as long as only dubious general nerve symptoms are present, diagnosis is often difficult. Even when meningitis is diagnosed, it is often difficult to ascertain what form of meningitis is present. Roentgenograms of the lungs should be made, and they are often valuable, especially if the lungs already show signs of miliary tubercles, but negative results do not by any means exclude tuberculous meningitis, as miliary tubercles in the lungs often develop late, sometimes only shortly before death. Lumbar puncture is instructive. The tubercle bacillus is found only in from 80 to 90 per cent. of the cases and often requires several days of patient search. Lymphocytosis can only be regarded as a possible indication. Increased pressure as shown by lumbar puncture is important, but more valuable still is evidence of an increased albumin content of the cerebrospinal fluid, for which Pandy's reaction is the most reliable and practical method. This consists in adding a drop of cerebrospinal fluid to 1 c.m.m. of 7 per cent. phenol solution. Cloudiness at the zone of contact is a sign that the fluid contains easily precipitable albuminous substances in pathologic quantities. In a series of fifteen cases the Pandy reaction was positive.—*Jour. Amer. Med. Asso.*, April 17, 1920.

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## NERVOUS AND MENTAL PHENOMENA OF HYPERTHYROIDISM.

BY

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(Read before the Alethean Club, Boston, Feb. 13, 1920.)

THE nervous phenomena of hyperthyroidism are so marked as to lead to the inclusion of this pathological condition in all text books on nervous diseases. Ever since the true nature of exophthalmic goitre has been understood, there has been some question as to whether it should be considered primarily neurological, medical, or surgical; each view still has its protagonists, but from the wealth of nervous symptoms and their relative importance, it can readily be seen why neurologists at least, are inclined to look upon this disease as coming under the first caption.

There is still some debate concerning the true mechanism of this disease. It is generally assumed that the symptoms are referable to the enlarged and overacting thyroid, but to what is the overactivity of the thyroid due? The ability of violent or repeated emotional shocks to increase the size and activity of the thyroid gland has been strikingly illustrated in the recent war. Cases are recorded in which typical Graves' disease developed rapidly under the strain of war, notably in civilians who were under bombardment, in constant fear of death, and viewing the sudden death of relatives and friends. Those who had opportunity to observe cases of war neuroses are familiar with the frequency with which thyroid enlargement and tachycardia were encountered. In civilian practice, attention

has been called to the fact that the goitre itself is frequently not the earliest symptom. Oppenheim mentions the fact that in the parents and children of persons suffering from exophthalmic goitre, he found vasomotor neuroses in many instances, this suggesting that the patient himself probably possessed an unstable nervous system. Indeed, a "hyperthyroid temperament" has been described, among the characteristics of which are enumerated easy perspiration, a tendency to wink excessively, and to sleep but little. Leaving aside the tenability of the theory of innate predisposition, however, we may say that the thyroid enlargement frequently follows other evidences of nervous disorder. In the first place, the patient may have been undergoing unusual mental or physical strain (Crile goes so far as to say that a psychic factor in the nature of strain is always found in Graves' disease). He becomes restless, irritable, sleepless, begins to lose weight, develops tremors and tachycardia, and finally, perhaps after several months, his thyroid shows enlargement. We must grant, of course, that the secretion of thyroidin does not directly depend upon the amount of secreting substance, and that hyperthyroidism may exist without goitre. Nevertheless, there would seem still to be some reason to believe that in its origin, at least, Graves' conception of the disease as a neurosis may not be wholly devoid of truth. In this connection, it is interesting to note that in one case the section of the cervical sympathetic nerve decreased not only the pulse rate and exophthalmos but also the goitre. May this not be interpreted as signifying that the section of this nerve prevented the passage of impulses which were stimulating the thyroid? If this, indeed, be the case, thyroidectomy can at best be only palliative. But to other less debatable points.

Many of the most striking symptoms of this disease are due to irritation of the sympathetic nervous system. In connection with this statement it is of interest to note that it has been demonstrated that the cells of the superior cervical sympathetic ganglion in patients suffering from Graves' disease show degenerative changes which parallel the stage and intensity of the symptoms. As the process subsides, the destroyed cells are taken up, so that the histological picture bears a relation to the continuation and remission of the clinical findings. The exophthalmos, for instance, one of Basedow's original triad, is said to be due to increased tonus of the mus-



culus palpebralis, which is innervated by the sympathetic nerve. This exophthalmos varies greatly in degree and in some cases is unilateral; it may result simply in a slight widening of the palpebral fissure, or may produce a marked prominence of the eyeball. In connection with this symptom is to be mentioned v. Graefe's sign, an inability, total or partial, of the upper lid to follow the eyeball when looking downward. This is attributed to tonus of the levator palpebrae superioris, resulting from invitation of the sympathetic. Mydriasis likewise is often present, but not of such intensity as to cause abolition of the light reflex.

Another symptom due to the same cause is tachycardia. This is one of the very early and important symptoms. The pulse rate is consistently greater than normal, varying anywhere from 100 to 200 per minute; the average is from 120 to 140. Emotional disturbances cause marked acceleration, a fact not to be forgotten in the treatment. At first, at least, the size of the heart is normal, the action is strong, and with the exception of an occasional systolic murmur of the so-called functional variety, the sounds are of good quality. In the later stages of the disease, however, the effects of long-continued overaction often manifest themselves and we find evidences of hypertrophy or even dilatation, causing at times a fatal outcome. The functional disturbance, in short, may in time produce definite organic changes. In addition to tachycardia, we usually find arterial hypertension, and cases are reported in which a systolic pressure of 250 mm. was present. Attacks of palpitation are not infrequently encountered.

Another of the cardinal signs, also probably due to sympathetic irritation, is tremor. This tremor is fine and vibratory in character, and the oscillations occur at the rate of from 8 to 10 per second. The oscillations are fairly regular, but are considerably increased in extent by psychic disturbances. The tremor is present at rest and voluntary movement is virtually without influence on it. Although this tremor is most marked usually in the fingers and hands, it is by no means confined to the upper extremity. Almost any of the voluntary muscle groups in the body may be affected. The tongue, lips, eyelids, the diaphragm, and the other muscles of respiration are among the more frequent sites of the tremor.

Still another fairly frequent symptom is hyperidrosis, usually general but occasionally unilateral. It is also noted

that the skin flushes easily, and at times telangiectatic areas are seen. Local edema also is a feature, usually being present in the eyelids. Areas of pigmentation of the skin or mucous membranes, resembling those seen in Addison's disease, lipomas, blanching and falling of the hair are other less frequent manifestations of a trophic disturbance of the skin.

Certain ocular signs have already been mentioned, but there are also numerous others which are less frequent. Among these are optic neuritis and atrophy, external ophthalmoplegia, lachrymation or the reverse, and nystagmus.

The deep reflexes may be increased or decreased; they are practically never abolished. Monoplegias or hemiplegias, transitory in type, are rarely observed, and paraparesis has been reported. There is a possibility that these phenomena may be sometimes of hysterical origin. A case of acute ascending paralysis, resembling that described by Landry, and one of gluteal atrophy, have been reported. Paraphasia is another rare symptom. Paralysis of the trigeminal or facial nerve is very unusual. Headache is not uncommon, and at times assumes the form of hemicrania. Disturbances of general sensation are almost unknown, except for a drawing pain in the body or limbs sometimes experienced.

If the neurological signs are fairly definite, however, the same cannot be said of the mental symptoms. A characteristic hyperthyroid psychosis does not exist, but psychotic episodes are not infrequent during the course of the disease. Such an episode may precede, accompany, or follow the acute physical signs, and is usually proportionate in degree to their intensity. Authorities seem generally agreed that the basis for these outbreaks is a psychopathic predisposition, the thyroid intoxication being simply the exciting cause. It is interesting in connection with Crile's "kinetic drive" concept that whether the patient be elated or depressed, some increase in motor activity is nearly always present.

Not infrequently there is found a certain amount of mental dulling. The memory is poor, as is the judgment, and the patient is easily fatigued mentally. The emotional tone in the majority of cases is one of euphoria and exhilaration. The patient becomes overtalkative, overdresses, takes an unwonted interest in outside amusements, and in general shows a personality change such as we are familiar with in the manic phase of manic depressive insanity. Irritability is a very fre-

quent symptom in such a state. Or again the patient may become anxious, hypochondriacal, tearful and depressed, this depression all being of the so-called "agitated" type. Hallucinations are not infrequent, especially visual; insight, however, is usually present. Still another picture presented is that of confusion, and frequently in the last stages an acute delirium is found. To use the classification generally employed, about one-half the cases resemble manic depressive insanity; most of the remainder simulate toxic psychoses (which indeed they are), and a few might at first glance pass for dementia praecox.

Some patients, without presenting a frank psychosis, evince certain isolated psychotic or neurotic symptoms over a longer or shorter period, such as impulsive ideas, variable emotions, excitability, terrifying dreams and sleeplessness. The last named symptom is indeed a fairly common one, although on the other hand sleep of an almost stuporous character is sometimes encountered.

Such, then, in brief, are some of the more salient nervous and mental phenomena of exophthalmic goitre. They furnish an interesting and tempting field for study and speculation, and it is to be hoped that future investigation will enable us still further to understand the true nature and workings of this disease.

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## THE PATHOLOGY OF HYPERTHYROIDISM.

BY

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(Read before the Alethean Club, Boston, Feb. 13, 1920.)

ABOUT four-fifths of all cases of hyperthyroidism show a diffuse, more or less knobby enlargement of the thyroid, which varies considerably but averages about a fifth greater than the size of the normal gland. The enlarged organ is dense and inelastic; its cut surface is lighter in color than the normal and exudes a rather thin fluid. Usually there is increased vascularity, which during life may be indicated by demonstrable pulsation. It is probable that dysthyroidism appears particularly in glands that were previously diseased, so that colloid and adenomatous tumors are not infrequently found. This explains the great variety of reported histologic findings.



A variable increase in size and number of the glandular lobules and follicles is a sign of previously existing hyperplasia.

Histologic changes that are characteristic of *morbus Basedowii* include:

1. Changes of the contents of the glandular acini, consisting of—
  - a. Partial or complete liquefaction of the stored colloid, which may then be present in varying stages of fluidity and in variable quantity;
  - b. The cessation of storage of fresh colloid material;
2. Cellular changes that may lead—
  - a. To the formation of club-shaped or cylindrical epithelial elements;
  - b. To an increase of the number of cells, finding expression in folds, processes, simple and branched papillæ and stratification of the epithelium. But new formation of follicles does not occur in great degree. Desquamation of epithelium into the glandular lumina is found, perhaps, somewhat more frequently than in simple goiter.

In cases of marked epithelial change (columnar or cylindric cells, formation of papillæ) and of marked reduction of colloid the microscopic picture becomes characteristic and easily recognized; whereas in other cases the changes are less pronounced and more or less irregular.

The connective tissue of the thyroid gland is not increased in case of Graves' disease. Accumulations of lymphatic tissue, particularly subcapsularly, are often found, sometimes with lymphnodes showing germ centers. Simmonds found these in 75 per cent. of Basedow strumas, but also in 15 per cent. of other strumas that bore no relation to status lymphaticus. They appear occasionally also in thyroids of normal size, especially in the female sex after puberty and more frequently with increasing age. In Graves' disease these lymphoid accumulations must probably be regarded as expressions of a reaction to the changed secretion, or they may have some relation to iodine therapy. Kocher found similar lymphatic foci in peri-thyroidal tissue, and the regional lymphnodes also are often hyperplastic.

Aside from the condition of the thyroid prior to the onset of Graves' disease, the degree and length of time of ex-

istence of this disease, as well as certain individual variations and unknown factors determine in part the histologic picture. In improved cases the colloid becomes thickened, and cellular hypertrophy and hyperplasia recede and may entirely disappear if recovery is complete.

Chemical examination shows the iodine content of the colloid material to vary with its consistency.

It seems, then, that the pathogenesis of the disease depends upon rapid or sudden absorption of the more or less increased or concentrated stored colloid, with greater or lesser hypertrophy or hyperplasia and partial exhaustion and degeneration of the parenchyma, and absence of storage of new colloid.

Anatomical changes of organs other than the thyroid gland include often a left-sided cardiac hypertrophy, probably a result of tachycardia, a lipomatosis of the musculature of the body and even more frequently, perhaps, thymus persistency and hypertrophy, at times combined with status lymphaticus.

This thymus hypertrophy has been found in about 74 per cent. of all autopsies done upon those who were, at the time of death, suffering from hyperthyroidism, and most often in those cases who had died immediately after thyroid operations, somewhat less often in those dead from the effects of the disease itself, and in a very small number of those who had died from an intercurrent disease and in whom Basedow's disease was of varying degrees of intensity.

The size of the thymus varies from a barely recognizable increase to one showing five times the normal maximal weight. The cause of the thymus enlargement is not clear, although Klose, *et al.*, suspect an indirect action through the ovaries which, in turn, have been damaged by the dysthyreosis.

Hypoplasia of the chromaffin system, which has often been found in hyperthyroidism, is probably to be looked upon as a part or result of the status thymo-lymphaticus that may accompany Graves' disease.

Of special interest are the hæmatologic changes observed in exophthalmic goiter. It is stated that there is lymphocytosis of from 30-37 per cent., with or without coexisting leukopenia. While it is true that many cases of dysthyreosis show abnormally high lymphocyte percentages, I cannot accept a percentage of less than 40 as evidence of lymphocytosis in view

of the fact that normal individuals may show an equally high percentage, even when strict regard for proper blood-smearing insures optimal uniformity of leukocyte distribution, and when the method of counting allows for an irreducible residuum of distributional irregularity of leukocytes on the slide. Hence, Aschoff fails to disprove the recently advanced theory that thymus hyperplasia bears a causal relationship to lymphocytosis in hyperthyroidism by citing a case showing *intra vitam* lymphocyte percentages of 36 and 38 and no trace of thymus tissue at necropsy.

Blood of hyperthyroid patients shows lengthening of the coagulation time, lowering of the freezing point and often hyperglycaemia. It has, until recently, been believed that there is an increase of adrenalin in the blood of those ill with Graves' disease, but this is beginning to be doubted, because Gottlieb has found that the adrenalin-like substances that act upon the sympathicus appear only after coagulation of the blood and cannot be demonstrated in the plasma.

The demonstration in the blood of substances derived from the thyroid is possible only by indirect means, that is, by their action upon certain chemicals. The decomposition of some poisonous substances is inhibited, so that their toxicity becomes altered. Morphin, for instance, which is detoxicated by decomposition, is more toxic for hyperthyroid cases by reason of this inhibition of decomposition, and other substances, as acetonitril, for example, whose poisonous components are liberated only when chemical splitting occurs, are less harmful for such patients. These facts have been demonstrated experimentally in mice fed with thyroid.

In exophthalmic goiter there is, according to Kocher, always an increased absorption of thyroid secretion. Feeding with thyroid and iodine preparations causes aggravation. Experiments by Klose, Lampé and Liesegang, however, speak rather for a qualitative change of thyroid secretion, that is, a dysthroesis. Believing that there is present in this disease a constitutional predisposition, they gave intravenous injections of juices expressed from thyroids to terrier dogs that were racially degenerated by inbreeding. While juices obtained from normal thyroids and ordinary goiters did not produce poisonous effects, those derived from *struma Basedowii* caused a characteristic symptom complex including fever, tachycardia, severe nervous phenomena, albuminuria and glycosuria, arter-



ial hypotension, tremor and exophthalmos. The same result followed injection of potassium iodid. Furthermore, the fact that symptoms of Basedow and myoedema occasionally occur side by side is more easily explained by the assumed presence of a dysthyreosis.

But this question can thus far not be regarded as answered, since Baruch, for instance, was able to produce diseases simulating Basedow by intraperitoneal injection of dogs with macerated parenchymatous goiters as well as with Basedow strumas, and E. Bircher obtained similar results by implanting dogs with freshly obtained thymus from thyroid-healthy humans.

Metabolic disturbances found in Graves' disease are in accord with those found in experimental hyperthyroidism produced by feeding thyroid extract to animals. This influence upon metabolism is constantly observed and expresses itself in increased protein catabolism, greater destruction of fat, and heightened calcium and phosphorus excretion. There is lowering of blood pressure, often accompanied by accelerated heart action, although it is questionable whether or not these effects are specific.

Continued feeding of extract may lead to thyrotoxic symptoms resembling those found in Basedow's disease, and those observed in man as a result of excessive therapeutic doses of the extract.

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## HYPERTHYROIDISM IN PREGNANCY.

BY

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(Read before the Alethean Club, Boston, Feb. 13, 1920.)

OTHER papers have covered or will cover the various disturbances, functional and otherwise, referable to the diseased thyroid gland and their effect upon metabolism as a whole. While in the short time herein allotted it is impossible to enter into any discussion of the metabolic changes induced by pregnancy and their relation to the metabolic and other changes developing in hyperthyroidism, nevertheless it remains almost axiomatic that these two conditions when intercurrent are of

great importance and their effects upon the patient must be carefully studied and weighed.

The interrelation of the female reproductive system and the thyroid gland is evidenced in one phase by the physiological enlargement of this gland which frequently occurs during menstruation. Experimental evidence has conclusively shown also that there is a very definite relation between the thyroid and the sex glands, both being classified as ductless glands of internal secretion. The manifestations of pregnancy are evidenced chiefly upon the circulatory and nervous system, resulting in certain definite metabolic changes. The manifestations of hyperthyroidism are evidenced largely in similar directions. During pregnancy, moreover, it is not uncommon to find a so-called physiological enlargement of the thyroid gland, although the development of a true exophthalmic goitre is rare. Symptoms of hyperthyroidism, however, such as hysteria, palpitation of the heart and various gastro-intestinal and nervous disorders are more common than has been previously believed; and such evidences of hyperthyroidism do not need a confirmatory exophthalmos to render the diagnosis certain. Many such questionable cases should receive more painstaking diagnosis and more continued observation.

Such symptoms are especially likely to occur from the second to the fourth month of pregnancy, after which improvement occurs more often than further aggravation, such aggravation being manifested then by rather rapid growth of the gland with or without exophthalmos. Continued or excessive hyperthyroidism is likely to result in hemorrhages or abortions. The blood pressure, which at times may be subnormal and at times increased, should be carefully watched throughout pregnancy in these cases. The possibility of eclampsia should always be borne carefully in mind. The ammonia coefficient of the urine is the most useful index to impending eclampsia; and when this reaches 15 per cent. or more the uterus should be emptied unless the ammonia nitrogen can be reduced. If the child be viable Caesarean section offers a much better hope of avoiding the surgical shocks and acute iodism which are so to be feared in these cases than the forcible dilatation of the cervix with version and breech extraction. This might be modified, of course, in some multiparae.

Consensus of opinion at present is against surgical intervention for hyperthyroidism during pregnancy unless it be for

the purpose of relieving pressure symptoms, substituting instead rest and the suitable medical, dietetic and hygienic measures necessary for the individual patient. The injection of hot water into the gland, which has been advocated by Crile, has not found so much favor by reason of the danger of resulting death of the patient. This is probably due to defective technique, the water being not sufficiently hot in some cases to coagulate the albumin, with a resulting tendency of the gland to throw off a great excess of thyroid secretion. Far better results have been obtained by Crile and others by the injection into the gland of urea and quinine hydrochloride. While this cannot be claimed to be in any sense curative, nevertheless there seems to be sufficient evidence to show that the agent acts as a block within the gland itself for the time being, preventing excessive elimination of thyroid secretion, and thereby controlling the symptoms of hyperthyroidism resulting from such elimination.

Marriage and child bearing in patients with symptoms of hyperthyroidism have usually been deemed not advisable by reason of the severe constitutional disturbances often common to both. C. H. Mayo, however, recently takes a somewhat different view, stating that in a rather large number of pregnant patients with exophthalmic goitre, many of such patients were better during pregnancy than before it, and that in some of these the goitre disappeared after birth. Some cases, however, do grow unquestionably worse during pregnancy. He suggests also a rather radical departure by stating that if pregnant women were given iodine, the thyroid would convert it into the thyroidal iodine needed in the body, thereby relieving the thyroid of considerable work and improving hyperthyroid symptoms.

It has been recently suggested that the function of the thyroid gland may exert some influence on the duration of pregnancy, premature delivery being associated with hyperthyroidism while hyperthyroidism may seem to prolong the pregnancy. The assumption that the mental and physical development of children born of hyperthyroid or hypothyroid mothers may be considerably influenced thereby seems rather a long leap, but some Japanese observers have brought forth considerable evidence bearing upon the subject. Investigation along these several lines is urgently needed and promises interesting work and results.



**SOME DRUG AFFINITIES.**

BY

WALLACE MCGEORGE, M.D., CAMDEN, N. J.

(Read before the New Jersey State Homœopathic Medical Society, at Atlantic City, N. J., May 27, 1920.)

By affinity of drugs is meant a close relation or connection through natural attraction. For example: *Ceanothus Americanus* has an affinity for the spleen.

This paper is not a dissertation on organopathy, nor organotherapy, although both have their use; neither is it a compilation of characteristic symptoms, or keynotes, or guiding symptoms, all good, very good to the observant physician. It is written to demonstrate the celerity with which drugs that have an affinity for certain organs, or portions of the body, do their work when carefully selected.

Let us take a diseased condition readily observed, and the remedies that have an affinity for this part. If a patient comes to you with a sty (unless the totality of the symptoms calls for some other remedy), don't forget that if the sty is on the lower lid, sulphur will be the curative remedy; if on the upper lid, *pulsatilla*. If the sty had dried up and become a hardened mass, a chalazion, *staphisagria* or *thuja* will be more helpful. *Thuja* will be good in tarsal tumors as well as chalazion, but if the sty ulcerates, or if one sty follows after another, *staphisagria* will be the remedy your patient needs.

In diphtheria, note carefully which side of the throat is affected, or where the diphtheritic exudate began. If on the left side give *lachesis*, if on the right side, *lycopodium*. In this disease the animal poison works quicker than the club moss. *Lachesis* will remove the diphtheritic patch in twenty-four hours' less time than *lycopodium* takes.

*Arsenicum* has an affinity for the right side of the heart, phosphorus for the left side, *aconite* for the cardiac plexus of the vagus nerve. *Cactus* where there is grasping or squeezing of the heart, *spigelia* for endocarditis, *spongia*, to absorb the vegetative growth observed after valvular troubles. When *aconite* is the remedy, as in paroxysmal tachycardia, its curative effect is almost instantaneous.

Iodine in the 30th or 200th potency has an affinity for

goitre. It will reduce goitres of one to ten years' growth in from two to six months and make you many friends. In those cases where the goitre developed after childbirth, twenty, thirty, forty years ago, its effect is negative on the goitre, but it will improve the patient's general health.

Ceanothus will reduce an enlarged spleen to its normal condition, and entirely remove pain so often observed in these cases. Formerly it was given in appreciable doses of the tincture. In my experience, the thirtieth potency works quickly and with lasting results. The dull pain is relieved in three or four days, but it takes as many weeks or longer to reduce the swollen organ.

If a woman has ovarian trouble, many doctors calmly advise ovariectomy. It is more homœopathic, and less expensive, if the left ovary is affected to give lachesis, or if the right one, apis mellifica, than to maim the poor woman by using the knife. Let us treat these unfortunate and suffering women with the proper remedy, and not with the scalpel.

Negundo has an affinity for sore, troublesome, protruding piles. Try the first potency on the next stubborn case of hemorrhoids. If the rectum is more involved, with or without prolapsus, podophyllum will be the better remedy.

In neuritis, when the right shoulder is affected, think of sanguinaria. If it is in the left one, give ferrum metallicum.

In hip joint cases, when the left hip is involved, think of rhus tox, or calcarea carb. If the right hip, bryonia or ledum will suit better.

In sprains of ankle or wrist, or in stiffness or pain in these parts don't forget ruta graveolens.

In sciatica, gnaphalium 1st does good work. The nearer the pain is to the hip, the quicker the medicine works. If the pain is in the heel, sepia, high, will relieve more surely.

In angina pectoris, magnesia phosphorica, 3rd or 6th, given in hot water works nicely in those cases that indicate sclerosis of the coronary arteries. When the hardening of the arteries is in the cranium, glonoin works very quickly.

Let us not forget the mercury group. While in times gone by it has been abused, and many people have suffered long, weary years from its indiscriminate use, mercury, properly administered, saves many hours of suffering. It has an affinity for all the glands of the body, excepting the spleen. The soluble mercury of Hahnemann will heal a sore nose, in-

ternal or external, quicker than any other remedy, if given in the 30th potency, or higher. It is valuable, very valuable, in the treatment of so-called tubercular glands in the neck. Try *mercurius sol.* for two or three weeks, and save your patient the unsightly scar which usually follows surgical treatment, and win the gratitude of your female patients, by your skill in curing and not cutting them.

In follicular tonsillitis, *merc. jod. flav.* 30, always cures my cases. In cheesy exudates from the tubes in the tonsil, with offensive breath, it is the *similimum*.

In laryngeal troubles, where the vocal cords are involved, with aphonia *merc. jod. rubrum* 30, cures cases that throat specialists have been unable to help. It makes the general practitioner feel good to see the indicated remedy cure his patients of their loss of voice, when specialists have been helpless, and unable to restore speech to them. That counts for homœopathy.

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## THE RESPONSIBILITY OF THE PHYSICIAN IN THE PREVENTION OF DULL HEARING.

BY

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(Read before the Philadelphia Clinico-Pathologic Society.)

THE physician who has made a thorough study of dull hearing as found in the adult portion of his practice, is impressed with the fact that the majority of these patients give a history of catarrhal conditions of the upper respiratory tract since childhood. Furthermore, the one who has made thorough functional tests of the hearing of children, has found that a goodly percentage of supposedly normal children exhibit either constant or intermittent dull hearing. It is our belief that the chief cause of this dull hearing, and we may say the chief cause of catarrhal conditions of the upper respiratory tract can be traced to the infections arising from adenoids. This may seem rather a broad statement but we feel that it will be borne out by careful study.

While the catarrhal symptoms produced during adenoids, the cold catching tendencies, the mouth breathing, the retrac-



tion of the drums and dull hearing, subsequently disappear, or become lessened as the adenoids disappear, it will then be found upon careful study that the accessory cavities of the nose and the upper respiratory tract have become diseased and that a rather chronic condition has been produced with an extension of the catarrhal trouble. The ear conditions, which up to this time have been intermittent in character, due to the fact that the condition in the eustachian tube and middle ear is in the early stages, commences now to change in character and we then find pathological conditions in the eustachian tube and middle ear which result in a more profound and permanent degree of dull hearing.

The individual has normally three or four times the amount of hearing necessary for ordinary life and for this reason his attention is not called to his loss of function until a large portion of the hearing has been lost; furthermore, the catarrhal type of deafness is of a very insidious character, it taking, in the majority of instances, a number of years before a marked state of dull hearing is reached. It is due to these facts that so many of the cases are not recognized until a stage of the disease has been reached in which the pathological changes are of such a nature that improvement by any method of treatment is often doubtful.

If the physician would make it a rule in his practice to regularly and carefully test the hearing of the children whom he is called upon to treat, he would be surprised to find how many there are who exhibit intermittently either slight or more profound degrees of dull hearing. We are too prone to pass over so-called colds in the head in childhood, treating them medicinally without thinking that recurrences of such conditions, in the majority of cases, point to some abnormality of the upper respiratory tract and that these recurrences must ultimately bring about a condition of profound dullness of hearing later in life. If we would realize the extreme importance of careful searching for a cause of these colds we would then bring about a cessation of them and would ward off the future complication of dull hearing.

We have stated that, in the early stages, the dull hearing is intermittent. This is due to the fact that there occurs, from time to time, an infection of the eustachian tube with closure, this bringing about a cessation of its function with dull hearing and the objective appearance of depressed drums.

After this infection has run its course the ear returns practically to normal during which period the dull hearing will naturally disappear until reinfection occurs and the child has another so-called cold in the head, when the hearing will be found again to be dull and the drums depressed. There may be many such attacks before any appreciable damage is done to the hearing structures, but ultimately there must result, through repeated attacks a lessening of tissue resistance with a gradual tissue change and the condition passes into one in which more or less permanent dull hearing will be found.

Much has already been accomplished, indirectly, in the schools to ward off dull hearing by the systematic examination of nose and throat, the attention of the parents having been called to tonsils and adenoids, has resulted in many cases being operated, thereby preventing a future chain of catarrhal symptoms, which would have remained had these conditions not been removed. Had there, however, been associated with these examinations a testing of the hearing both before and after the operation it would have been found that a percentage of these operated cases still retained a certain amount of dull hearing. Had these cases been further examined and treated results would have been far better.

In the average operation too little attention is paid to the fossa of Rosenmüller, the adenoid being allowed to remain in the fossa thereby causing a continuation of the subjective symptoms as well as the dull hearing. This is often the cause of disappointing results after adenoid operations. We have had the opportunity of examining many children who have had previous adenoid operations, in whom, upon accurate testing, we have found dull hearing, and upon examination of the nasopharynx have found there were still remaining considerable masses of adenoid tissue in the fossa of Rosenmüller. The majority of these cases promptly responded to the removal of this tissue as evidenced by the marked improvement in the hearing and return of the middle ear condition to the normal. Furthermore, we have seen cases in which symptoms of focal infection were evident, these symptoms disappearing upon removal of a purulent focus in the fossa of Rosenmüller.

Adenoids are frequently overlooked in children because of the misunderstanding which the physician has as to the symptoms produced, it being thought that the child with this condition must be necessity have marked nasal obstruction; and

many children are passed along as normal because this condition of nasal stenosis does not exist. It is, however, quite possible for a large amount of adenoid to exist within the nasopharynx, if properly located, and still nasal breathing may be perfectly normal and it is also possible for small amounts of adenoid to be present and produce marked changes without a condition of nasal stenosis. This being so we must have ways of determining adenoids in order not to overlook this class of cases. The determination of adenoids is, of course, readily made by means of digital examination, or by means of post-nasal rhinoscopy, or examination by means of a naso-pharyngoscope if the examiner be skilled in these methods, but as many are not so skilled, it becomes necessary to pay close attention to the clinical symptoms, which if carefully studied, will become a marked aid in the diagnosis. The child suffering from adenoids may exhibit one or more of the symptoms of this condition, but it is not necessary for the entire picture to be present in order to suggest their presence. Children with adenoids are subject to frequent colds in the head, these usually disappearing in the warmer months. A certain number are loud or mouth breathers when asleep. They tire easily when at play. They cough frequently at night. They are restless in their sleep, talking in the sleep, often have nightmare. A certain percentage have nocturnal enuresis. Some show high arched palate. Nearly all exhibit intermittently slight or marked dull hearing when properly and carefully tested. If the ear drums are examined they are found to be depressed and dull. We have seen this condition present in which the amount of adenoid tissue in the fossa of Rosenmüller was exceedingly small, but so placed in relation to the Eustachian orifice that it produced the above results as evidenced by the improvement after removal of the adenoid tissue.

It is evident from the foregoing that the responsibility of the prevention of dull hearing lies with the physician, that in order to prevent this condition the catarrhal conditions of childhood should be thoroughly studied and their cause discovered and eliminated. That in order to discover these conditions in their incipency, the physician must make oft repeated and thorough functional tests of the hearing of children and we believe that this should become a very important part of the school physicians' duty and that in our various districts we should urge this strongly as a measure of the greatest importance.



## THE TREATMENT OF DULL HEARING THE RESULT OF AFFECTIONS OF THE UPPER RESPIRATORY TRACT.

BY

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(Read before the Philadelphia Clinico-Pathologic Society.)

DULL hearing is a symptom occurring in a number of conditions of the ears, and in a large percentage of cases, abnormalities of the upper respiratory tract are responsible for the production of pathological changes in the eustachian tube and middle ear producing this symptom. Dull hearing may arise from diseases of the ear which do not have their origin in the upper respiratory tract. We are not dealing with this class of cases in this paper. We are considering only dull hearing as it occurs from tubal and tubo-tympanic conditions.

The treatment of dull hearing occurring as a sequel to upper respiratory affections begins with the child where, as has been urged by Dr. Palen, the hearing should be carefully tested and the ears watched for deviations from the normal. Early thorough removal of excessive or diseased adenoid tissue from the pharyngeal vault and careful and thorough eradication of tissue in the fossa of Rosenmüller constitutes the first step in the prophylaxis and treatment of the ears.

Following the operative treatment in children, the hearing should be tested from time to time and the position of the drum noted. It has been our experience that in young children, where the dull hearing has been recent and intermittent, that the pathological changes are usually superficial and confined to the tube and that the operation clears up the ear pathology. In cases which do not show prompt improvement in hearing following the operation it is of advantage to improve the position of the drums by practicing inflation a few times. In older children where the dull hearing has been of longer duration the changes in the tube are more marked. Here the best results are obtained by direct tubal medication, this being repeated as necessary and indicated by improvement in the tubal function.

The repeated cold taking as occasioned by adenoids and

diseased tonsils frequently produces catarrhal changes in the mucosa of the nose. For this local medication will do much to hasten improvement in nasal breathing and tubal activity. When the ethmoidal cells have taken part in the pathology we have found the Dowling argyrol treatment to be of the greatest service. We feel that where indicated that this post operative treatment is rather important and that the painstaking administration is handsomely rewarded. We have also found from experience that the exhibition of internal remedies properly selected has an undoubted field of utility. Our personal experience has not included a long list of remedies, but ferrum, pulsatilla, hepar, arsenicum iodide and kali iod are the ones which seem to cover the residual symptoms.

If we are to get the best results in the operated cases we must not neglect the help of the orthodontist. If the palate is narrow and high arched we should seek counsel. Unquestionably many failures to relieve mouth breathing in operated tonsil and adenoid cases are due to contracted nares which are dependent upon the action produced by the arching of the palate. The operation upon the adenoid and tonsil alone will not bring about the desired results. If we fail to establish normal nasal breathing we are certain to fail in the relief of ear conditions, hence the necessity of placing these cases under proper dental care.

We have experienced very gratifying results by placing certain of our operated cases under the care of a physical director who teaches corrective breathing exercises. This applies not only to children, but to cases later in life where they have been mouth breathers for a long period of time. We fail to give our patient the best when we simply operate and cast him adrift. The operation is usually but the beginning of the treatment which is going to normalize the patient.

Where the obstructed nasal breathing in childhood has been ignored, or where the post-operative supervision has been neglected, the contracted nares, high arched palate and consequent bending nasal septum continues, as it were, the action of the adenoid. It is a common clinical observation in cases of septal deviation to find dull hearing present. Frequently these patients come to us not because of falling off in hearing but rather consult us for purely nasal symptoms which have been accumulating and have reached the point of annoyance. Upon inquiry concerning the hearing they will admit

their hearing is not as acute as it should be and upon functional testing we find their hearing not a little but much impaired. In this class of cases we find the pathology has extended to the middle ear. Some will give symptoms of recurring attacks of acute tubotympanic catarrh with serous effusion. Clinical observations from the other direction substantiate this; that is, in cases of acute tubo-tympanic catarrh consulting us for relief of symptoms, we find septal deflections or other nasal obstruction interfering with free nasal breathing and drainage and we know from clinical experience that when the obstructions in the nose are relieved that these ear conditions show less tendency to recur.

It is not always a septal deviation which perpetuates the early symptoms of ear pathology. Repeated cold taking may result in hypertrophy of the turbinal bodies. Drainage from the nasal accessory cavities may become choked with resulting sinusitis and perhaps polyp formation. With each new "cold" the condition is aggravated, thus we have set up a chronic catarrhal condition which spreads rapidly to the posterior nares and the eustachian tube.

Repeated exhibition of acute nasal pathology, or sub-acute or chronic nasal trouble calls for not only a thorough investigation of the nose and throat, but also investigation of the ears and hearing. It will be surprising to you how many of these cases will exhibit advanced ear changes although the patient complains of the ear only upon direct questioning. It is unfortunate that so large a percentage of the laity and a too large percentage of the profession are resigned to accept oncoming dull hearing as an incurable condition. This will continue a fact as long as the nose and throat of the child are neglected, improperly or half heartedly treated; so long as the growing child is allowed to have his colds and nasal obstruction and so long as the adult patient is allowed to carry his nasal obstruction and catarrhal condition which gives him no special discomfort. The first attack of earache, fullness or buzzing in the ears or dullness of hearing is the signal for a most thorough investigation of conditions as outlined.

A well directed submucous septal operation, a turbinal operation, the establishing of free drainage to a suppurating sinus are often the first step in the treatment of a beginning or advanced dull hearing.

Following the correction of nasal, post-nasal and ton-



sillar conditions we have to deal with changes in the eustachian tube and middle ear. The extent of these changes usually, in uncomplicated cases, determines the extent of the dull hearing. It has been our experience that the cases complaining of recurring fullness in the ears offer the better prognosis for improving.

Inflation by means of the Politzer bag, compressed air or by way of the eustachian catheter has for many years been the recognized treatment. We have come to use these very rarely. Inflation is, at best, a makeshift, relieving the patient usually for a short period and has to be repeated frequently. Such repeated inflations, we believe, do harm in that it causes eventually a relaxation of the drum and stretching of the delicate articular ligaments of the ossicular chain. Direct medication to the tube produces a more definite and lasting effect. We further believe, unlike inflation, the good results from this method of treatment are cumulative. The medicament employed will vary with the case and the physician. The occasional passage of the Eustachian dilator is practiced with marked benefit in cases where thickening or stricture exists. We would warn against the too frequent use of the dilator as we believe such frequent use brings about destructive changes in the tubal mucosa.

General medicinal supervision in these cases is of greatest help. The diet and habits should be so regulated that the mucous membranes are not over-taxed. The elimination of excessive candy or other sweets, tobacco and alcohol is to be advised.

Summary: The treatment of dull hearing arising from affections of the upper respiratory tract begins in prophylaxis in childhood.

Proper post-operative supervision to see that nasal breathing is established and the catarrhal changes are controlled.

Counsel with the orthodontist in cases of contracted and arched palate.

Correction of nasal and naso-pharyngeal lesions as the preliminary step in the treatment of dull hearing.

## THE PRESENT STATUS OF CHEMOTHERAPY.

BY

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(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 18, 1919.)

CHEMOTHERAPY has opened a new vista in scientific medical treatment. This new method involves the discovery of chemical substances that have the effect of destroying the causes of disease.

Since Professor Paul Ehrlich began his famous studies of the effect of dye-stuffs on different tissues, many observers have undertaken to find chemicals suitable for the various diseases, *i. e.*, tuberculosis, malaria, cancer, syphilis, pneumonia, typhoid fever, etc. To understand the proper basis of all that is implied by the chemotherapy practice, it is necessary to recall the side-chain theory of Ehrlich, which represents the functional activity of the cell—how nutriment is taken up by the cell, and how it combines with toxins, to neutralize them and produce bodily immunity to disease.

As you recall, his theory is that each cell has a receptor, which is capable of combining with toxins, chemical compounds such as dyestuffs, etc. All diseases produced by protozoa, like the plasmodium of malaria, the trypanosome of African sleeping sickness, the amoeba of dysentery and the spirochete of syphilis, contain various atom groups, or receptors, as simple cells do. These, which Ehrlich terms chemoreceptors, are able to enter into chemical relationship with certain germicides, introduced into the blood. The germicide can unite only with a receptor of its own class; other atom-groups in the cell or the parasite reacting with the other classes of antiparasitic agents.

Thus, arsenic, in the form represented in salvarsan or arsphenamine fixes itself on the arsenoreceptors of the spirocheta pallida; and the syphilitic parasite either dies immediately or is taken care of by the phagocytes of the blood. At the Frankfort Congress of the German Dermatological Society in 1907, Ehrlich introduced a compound known as arsacetin as a remedy for syphilis. After many experiments, he was able to produce another substance in which arsenic could be introduced in large amount, giving doses large enough to

kill the parasite and, at the same time, be less toxic or injurious to the tissues of the body. The solution was found in dioxydiamidoarsenobenzol, or salvarsan.

In tuberculosis, we have quite a different problem. Instead of a delicate naked organism, circulating in the bloodstream, we have an organism protected by a membrane that is only with difficulty permeable, usually in nonvascular and often necrotic cells or groups of cells. To get at the organism of tuberculosis, we must have a compound that will permeate the necrotic mass; such substance must be a crystalloid or semi-crystalloid, which will influence the tubercle favorably or unfavorably—first, by breaking down the tissue and permitting its absorption; secondly, by favoring connective-tissue formation and calcification; and, thirdly, by attacking the bacilli themselves.

A chemotherapeutic agent, to be of value in tuberculosis, must inhibit the development of the tubercle bacillus to such an extent that further growth is impossible. In order to produce any of the foregoing effects, it is necessary for the chemotherapeutic agent to enter the diseased tissue in concentration sufficient to produce either a bactericidal or an inhibiting effect; and this, without material injury to the host. If the chemotherapeutic agent enters in concentration nearly equal to that in the blood, it should remain there, without harm to the host, in concentration sufficient to be inhibiting. Repeated introduction must be resorted to, in order to keep up the inhibitory action until a permanent effect has been produced, or until the host is in such a condition that further immediate development of the disease is impossible.

Many drugs and chemicals have been tested as to their value in tuberculosis, especially in the lower animals. If anything would cure the disease in guinea-pigs, it would almost certainly do so in man; but it is quite possible that some treatment might cure the disease in man that would have little or no effect on the same disease in the guinea-pig. If we find that in a large series of animals, a given treatment uniformly and consistently delays death, lessens the dissemination of the tubercles, causes connective-tissue formation and inhibits the growth of the tubercle bacilli, even though the infection is not cured, we have a right to conclude that it is worth consideration and trial on human patients, even when it must be subjected to observation over a long period of time on a large



number of patients before it can be accepted as of value in tuberculosis therapy.

Many compounds have been tried. Iodine is one of the substances longest used in the treatment of tuberculosis. It has been demonstrated by DeWitt and Sherman that iodine has little, if any, therapeutic effect upon the tubercle bacillus. Sodium sulphocyanate has been found to have no chemical affinity for tuberculous tissue, and no bactericidal effect on tubercle bacilli *in vitro*. Various forms of arsenic compounds have been tested as to their chemotherapeutic effect upon tuberculosis. Sodium cacodylate in no way modifies the progress of a tuberculous infection in guinea-pigs. Wells, DeWitt and Corper showed that sodium arseniate, sodium cacodylate, arsacetin and neosalvarsan did not kill the tubercle bacillus *in vitro*. They penetrated tuberculous tissues, but had no effect on the progress of the disease in animals.

Many heavy metals have been tested as to their chemotherapeutic effect upon tuberculosis in lower animals. Koch regarded the gold salts as of high inhibitory value in tuberculosis. Bruck and Glück obtained good results with gold potassium cyanide, especially in lupus. No works on the mercury therapy of experimental tuberculosis have, as yet, been published. The toxicity of the simple mercury salts has necessitated the making of new preparations, less toxic for the animals' tissues, while still preserving a high parasitocidal and inhibitory power. In spite of its low tuberculocidal power, copper has received more attention than the other metals, for investigation in the chemotherapy of tuberculosis.

As early as 1885, Luton recommended the use of copper in human tuberculosis. Many investigators have attempted to use copper, but failed to obtain any good results. In 1915, Koga read before the Kitasato Institute of Infectious Diseases, Tokio, Japan, an elaborate communication on his results with a compound of copper and cyanide. He claimed that the injection of this preparation caused leukocytic infiltration, with the absorption of degenerated products and new connective-tissue formation. Cooper analyzed for copper the tissues of many tuberculous animals treated for long periods with different preparations of copper, but found no appreciable amount of copper in the tuberculous area and observed no effect on the course of the disease.

Dyes which can be introduced into the living body without material injury have been tried by Ehrlich.

Because both tubercle bacilli and tubercle are rich in fats, fat-soluble dyes have been used. Sherman found that the ordinary fat dyes, Sudan III, Sudan yellow, Sudan brown, scarlet and Nile blue, penetrate and stain individual tubercle bacilli but little, if at all. Corper also reported that these dyes, when administered to tuberculous guinea-pigs until the normal body fats were brilliantly stained, were never found within the tubercle and never stained the bacilli within the tubercle.

Lewis used trypan blue compound with iodine, thymus, eucalyptol, guaiacol and iodoform, with no appreciable influence in prolonging the course of the infection. DeWitt also, in the hope of increasing its therapeutic power, compounded trypan blue with copper, silver, iron and mercury. These salts were, however, more toxic, and had little more influence on the course of the disease than had the trypan blue. Methylene blue penetrates the tubercle and stains the tubercle bacilli *in vitro* very well; basic fuchsin, crystal violet and rosine also stained the tubercle bacillus well.

Bismarck brown, brilliant cresyl blue and methylene blue have some bactericidal power and marked inhibitory influence on the growth of the tubercle bacillus *in vitro*; yet these dyes have not shown any considerable curative effect in the experimental disease in guinea-pigs.

So far, then, our chemotherapeutic studies have resulted in no experimental demonstration of any clinical specific for tuberculosis. Gold, mercury and certain dye compounds are still on trial.

The compound of copper cyanide has been used for leprosy. The communication of Tahano reported six cases of leprosy that had shown some beneficial effects from the administration of this compound.

Little has been done or reported on the chemotherapy of cancer. The only communication is that of Wassermann's experiments. These investigations were based upon the discovery that sodium selenate and sodium tellurate reduced cancer cells. And for these metals to reach the tumor cells a substance must be used to carry them. After many experiments eosin was selected because of its great power of diffusion. Eosin-selenium compounds have been tried out, the results showing that in a number of instances the tumors became soft and sloughed away or their further growth was checked.

The problem of treatment is to find some substance that

will exert a destructive action upon the malignant cells, while the other cells of the body remain uninjured; but the difficulty of discovering such an agent becomes more and more evident as we constantly fail to detect any distinct difference between malignant and normal elements. Clinical results so far reported, and even the experimental work, do not, as yet, give much support to the efficacy of chemicals in the treatment of pneumonia.

It must be concluded that the observers along these lines are still working on the chemotherapy of tuberculosis, cancer and pneumonia; and it is to be hoped the day will come when a compound will be discovered for these diseases, like salvarsan for syphilis.

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### PERNICIOUS VOMITING OF PREGNANCY.

BY

H. MALCOM READ, M.D., YORK, PA.

(Read before the Central Pennsylvania Homœopathic Medical Society,  
October 16, 1919.)

My subject for this afternoon, gentlemen, is not at all new and I shall not expect to give you any particularly new or advantageous tips or advances in this disease; but, if I shall condense into a short talk the old disease as written in the books on Obstetrics and in Medicine, I shall feel more or less rewarded for my little effort in placing it before you for your pleasure or discussion. Remember that you have to listen to a younger member of the Society, and, one who has been in the army and only practicing medicine for the short space of nine months all told, and you shall relieve me of any embarrassment that may accrue from your open exposure of my shortcomings or misgivings.

In hyperemesis gravidarum we have an increase or persistency in the usual distressing symptoms of "morning sickness" of the pregnant woman. In other words, we have to deal with vomiting, persistent, severe, pernicious, and often fatal, with death to both fetus and to mother, unless indicated measures are at once instituted.

ETIOLOGY.—In so far as the causative factor or factors are as yet but in the experimental stage we are not justified in



saying that any one particular finding or set of findings is always present. Let it suffice to say that there is an acidosis or a toxemia present which seems to be derived from some fault in the metabolism of this or that pregnant woman. It is a fact that in some cases there is a decided nervous influence, in others a decided toxicity, and in others a reflex causative factor which sets the process on its way. We do know that there is in the toxic variety a decided constant finding in the nitrogenous elimination on the one hand and in the nitrogenous accumulation on the other hand; between these two processes lies the ultimate solution.

In some cases of the toxic type there is to be found a true hepatitis, or fatty degeneration, if you will have it, or a liver necrosis; or there may be found the same destructive process in the renal structure and yet in other cases neither organ seems to be materially altered. We all know that there is some change going on during the pregnancy in a woman from the day of conception to the day of parturition, and it is up to us as practitioners to often find the differences in such women as to their toleration of certain substances and influences so as to allay a disturbed and altered metabolism during the ten lunar months that are to follow, and to allow these ten lunar months to pass just as ten months would pass were she not pregnant.

In the reflex type there may be a cervical laceration, a uterine displacement, a pelvic cellulitis, an ovarian cyst or tumor, or some other abnormality in the genito-urinary tract. In the neurotic type there is always a chance of finding the lack of the master mind, or a mind weakened through former disease, such as toxemia or infection, or the mind willful and not easily persuaded in accepting truth and fact; or, in other words, the non-receptive mind, the stubborn mind. In the toxic type there may be the chronic parenchymatous nephritis, or the fatty degeneration or infiltration, or even the chronic interstitial nephritis to contend with and then the hepatic conditions above mentioned. In all these types, the toxic, the reflex and the neurotic there is one fairly constant finding, that of changed metabolism as found in the skin, as sweat, the kidneys, as the urine, and the intestines as faeces.

**SYMPTOMS.**—In all types there is an exacerbation of the usual morning sickness; it becomes worse, less food is consumed, less urine is excreted and nutrition becomes below the

normal rapidly. The vomit at first of food taken; later and rapidly assumes the bilious kind and even to the state of hematemesis. Emaciation sets in and the pulse becomes rapid, then slow and death soon clouds the whole picture. The toxemic variety presents two kinds or sub-varieties, that of acute where the symptoms rapidly lead to severe vomiting, and then the ejection of coffee-ground vomitus and coma with seven to twelve days of this set of symptoms until the final outcome arrives with practically no emaciation and no other symptoms except the abnormal condition of pregnancy to look back upon. Then the chronic sub-variety where the course of the disease is longer, the vomiting is persistent, ejections of coffee-ground consistency follow repeatedly and emaciation due to inanition comes on. Then nervous symptoms further complicate the picture and in delirium or coma the patient asserts herself as a true toxic one and despite our most trying efforts the case goes on to the end, slowly but surely.

Since the pulse may be either rapid or slow and as there is no regularity to the acceleration or retardation of the pulse, there are no constant factors to be noted in this respect. As starvation continues there is naturally a retardation of the pulse until near the finish when the heart pumping on an almost empty chamber runs along headlong at top speed, often reaching 120 beats or more per minute. In the toxic cases one may find symptoms quite similar to those premonitory to eclampsia, headache, oedema, ocular delusions, vomiting and increased blood-pressure, but in no way must the practitioner believe that he has in this disease simply a forerunner of convulsions for whilst convulsions may possibly complicate the picture or ensemble, yet the pathological changes as observed post-mortem and the findings as observed in the patient before you, will rule out the existence of anything like a true eclampsia.

Jaundice may be an accompaniment as well as albuminuria, scanty urine and low total and ammonia nitrogen, and low urea. In fact, the disease may be actually followed by the urinary analysis and a favorable or unfavorable prognosis accordingly rendered by continued and repeated urinary findings.

DIAGNOSIS.—A mighty hard thing to do, and for the young practitioner a more difficult thing than for the older and more experienced clinician. It is entirely a matter of

plugging and repeated examination on the part of the physician so as to familiarize himself thoroughly with the case and set of symptoms at hand. There may be a slight suppression of the urine, with tubecasts and even blood in the urine, but not until you thoroughly examine the percentage of urea in the 24-hour specimen; and, further, have the nitrogen partition made, can you justifiably say that you are aware of the *type* of disease with which you have to deal. There is no guess-work, for even among the most careful searchers and diagnosticians there are occasional and repeated breaks, and the case assumes a reverse aspect with rapid death ensuing.

There may or may not be fever; the pulse may be rapid, as high as 120, or as low as 80, and yet you are no nearer to a conclusive or proper diagnosis. But, given a pregnant woman in the fifth to ninth week, with or without a previous history of pernicious vomiting, with a high ammonia coefficient exhibited in the urine, there is no time to hesitate, but to institute measures at once, and that means get busy and find out the cause if in any way possible, at yours or others disposal.

The normal amount of urine we know to be about 1,500 to 1,800 c.c. in women and slightly higher in the male when in health. In this daily output of urine there should be found on the regular mixed diet of an adult about 30 to 40 grammes of urea and with a total nitrogen of 10 to 15 grammes, and with a free ammonia nitrogen of about 0.5 to 1.2 grammes per 24 hours. *As a general thing and as a general symptom*, the ratio of total nitrogen to the ammonia nitrogen bears a certain number, namely, that of 100 to 5; or, in other words, the ammonia nitrogen should be about 1/20 of the total nitrogen excreted in the urine of the healthy person, be she pregnant or not pregnant. When upon examination the practitioner, or really the trained physiological chemist finds that the ammonia coefficient or bearing becomes way out of proportion and is 10 or 15 or even in severe cases as high as 30, then we know that there is real trouble ahead and something beneficial and curative is to be established at once. Here do we again say, repeatedly examine the urine, and don't quit until there is good reason to believe that the case is diagnosed properly and well under way for a complete recovery.

Here is a case where the "sink-test" won't get you anywhere, and trained and expert chemistry with perseverance will



only do the work. With an ammonia coefficient falling and with the vomiting decreasing with rest in bed and the proper moral suasion having been instituted you are practically assured that you are in the right diagnosis and can let the case honestly go on to the terminal parturition. With a rising ammonia coefficient, whilst it does not necessarily follow that there is the toxic type of vomiting with which you have to deal, yet you are relatively assured that you have a seriously ill patient, and careful vigilance is the professional high sign. These last remarks are clearly to be remembered as those of Williams in his *Obstetrics*. Remember, always, that the care in examining the patient and the elimination of one condition after the other is the only true and faithful way of reaching a conclusion satisfactory to both patient and to yourself as to the diagnosis of the disease and type of disease at hand.

PROGNOSIS.—In the neurotic and in the reflex types, when diagnosis is reached the prognosis is extremely satisfactory. Both types lend themselves most humbly to treatment. If some genital abnormality is found it is to be cleared up; if necessary, operated. If the case is a true neurotic case and gives a history of former pregnancies of such a character, you are to be the scientist and the moral or mental persuader and must at once tell and *convince* your patient that she is not ill but should make a rapid recovery with your intelligent and suggestive treatment.

Some patients may have experienced the toxic type with the former pregnancy and this time the neurotic type exhibits itself to the practitioner. In others, the neurotic type may have complicated the preceding pregnancies, and this time the toxic type is present. You are always guarded in your prognosis until you have thoroughly convinced yourself that you have seen and conquered the diagnosis and can meet it in the right way. The neurotic type should clear up in a week or two weeks; the reflex type depends upon the cause, and the toxic type may or may not yield to abortion, to treatment, or to suasion, be the cause acidosis, high ammonia coefficient or liver and kidney disease. Your prognosis is always reserved and guarded in the toxic vomiting of pregnancy.

TREATMENT.—We are compelled to start with the old dictum of rest in bed and absolute rest, for the patient may have a large and troublesome family which she is compelled to care for. Give absolutely nothing at all by mouth for 24 to 48

hours; if vomiting continues, then try gastric lavage, using a good strong solution of sodium bicarbonate. If patient becomes weaker and weaker then try rectal enemata, remembering not to use the egg-albumen under any circumstances; the preferable substances to use are the peptonized milks and the peptonoids or panopepton of Fairchild Brothers. Repeated lavage may relieve the symptomatic and persistent vomiting and rectal enemata may do for awhile, but in the toxic type there is bound to be a continued and gradual wasting and starvation which becomes appalling to both the members of the family and the physician. But, before there is this starvation, is the proper and justifiable time to induce the abortion or the miscarriage, as the case may have progressed in pregnancy. Digital curettage is presumed to be the best in the latter.

In the neurotic type the treatment is best administered by the sage and mystic physician who has his courage, his proper diagnosis and the ability to put it across. There will be a marked change in the condition of the patient in 4 to 8 days, and in many cases sooner. In other cases of the neurotic type there will be found the necessity of a nurse or even having the patient removed at once from the existing environ and taken to the seashore, or the mountain, or the country, away from the ever-present family and mob.

Daily examination of the urine is to be urged and the ammonia coefficient to be expressed in your report. The diet will have a very important bearing on the solid and nitrogenous excretion. Remember, that the remedy par excellence is water, plain, cool and clean, and given in as large quantities as can be tolerated by the patient. Then next comes milk, in all forms and in frequent and repeated doses. Peptonized milk is the most easily borne form of milk, and should be made fresh several times a day and given five or six times daily. Remember, that one of the keynotes is to feed the patient frequently, starting early in the morning and not letting up until night sets in. Be persistent in the treatment, and especially in the feeding, and there is bound to be success in all except the more severe toxic cases. Williams believes in feeding the patient with rectal enemata in severe cases but does not agree with some others that the results are all to be asked for.

Amongst the best remedies are both homœopathic and old school. I personally believe in the indicated homœopathic remedy and use it in almost all of my cases; the better remedies are kerosotum 6x, cerium oxalate  $\frac{1}{2}$  grain, cocaine hydro-

chloride  $1/6$  to  $1/3$  grain, nicotine 3x, bismuth subnitrate 5 grains, thyroid extract  $1/2$  grain or more, apomorphine hydrochloride  $1-1/100$  grain, or the 2x and 3x. For the toxic type or where there is coffee-ground vomitus, acidum aceticum 3x to 6x, is a good remedy. The return to a normal diet must be slow as the case progresses favorably, and a full diet can only be allowed when you are sure that the excretion is again normal and all accompanying signs negative.

CASE.—Mrs. S., housewife, age 26, white, married; 2 children living and well.

Chief complaint: Nervousness.

Family History: Father died at 47 years "acute indigestion;" mother living and well; four sisters living and well; possible family history of nervous disease. No tuberculosis, cancer, tumor or blood-disease in family.

Past Personal History: Measles, chicken-pox, whooping-cough, no operations; some slight vomiting before last pregnancy, described as severe morning sickness; habits good, as far as can be ascertained.

H. P. I.: Since last week in July of this year has not felt at all like herself; vomiting in the A. M., started and menses stopped with all accompanying signs of pregnancy. Vomiting became more severe than in the past pregnancies, and has persisted causing marked weakness. Domestic troubles came on, involving separation from her husband. Has lost weight continually for the past two months; no chill, no fever, no sweats. Normal weight, 122 pounds.

*Nervous System.*—Some severe headaches; vertigo with syncope; has had hysterical attacks lately with two so-called attacks of paralysis; has twitching and feels "terribly nervous." No tinnitus.

*Gastric System.*—Bilious vomiting worse in A. M., continual in character; no blood, and only relieved by hypnotic; constant nausea; constipated, and has some eructations of tasteless gas; persistent retching; pain in pit of stomach at times; no coffee-ground vomitus, but some tinging of pink material. No flatulence.

*Physical Examination.*—Patient under influence of a narcotic, pupils small and react to light; mentality normal, but somewhat retarded; conscious, well-developed with poor nutrition; lies comfortably in bed; no jaundice but a marked pallor with several ugly herpes labialis noted; respiration retarded but of thoracico-abdominal type. Patient seemed nervous and



worried at being questioned. No glandular enlargements, marked seborrhoea of face and head. Weight, about 110 pounds; temperature, 98.6; respirations, 22; pulse, 100; compressible but regular.

*Abdomen.*—No tenderness or rigidity of any quadrant; tympany throughout abdomen, except in pubic region where dullness is found. Tumefaction in pubic region with the fundus of the uterus about four fingers' breadths below the umbilicus; skin normal, linea striata of pregnancy noted.

*Thorax.*—Negative posteriorly to inspection, palpation, percussion and auscultation. Heart negative.

*Female System.*—Thick, purulent creamy leucorrhoea; streptococcus present; slight redundancy of posterior wall of vagina; cervix lacerated transversely; cervix points downward and backward; no tenderness and uterus freely movable but boggy and enlarged by bimanual examination. No tenderness in either side of uterus. No urethral discharge.

Smears of vaginal discharge showed no gonococci, but numerous flora and other mixed micro-organisms.

Vomit showed: Numerous leucocytes, some erythrocytes, mucus, no epithelial cells or tissue fragments. Blood-pressure: 'Systolic, 106 m.m.; diastolic 90 m.m.

Urinalysis: Specific-gravity, 1.014; acid, aromatic and 36 ozs. in the 24 hours. Acetone present, excessive indican, no diacetic acid, 21.60 gms. urea in 1080 c.c.; chlorides approximately normal. Broad hyaline casts present, very few small round epithelium, numerous spindle, numerous pavement epithelium; no unorganized sediment.

On second analysis: Trace of acetone, with excessive indican and only 15 grammes of urea in 1000 c.c. of urine. Few granular casts and few urates with small round epithelial cells present.

On third analysis: No acetone, moderate indican, no casts, no small round epithelial cells but few leucocytes.

At present writing the leucorrhoea has practically stopped, the patient has not vomited for four days, appetite good, weight better, color better, pulse regular and 86 per minute, no pains, is happy and talks pleasantly with nurse and doctor, bowels move by enema every day. Diet now increased from milk to gelatin, custards, junket, cornstarch, fruit juices and tomorrow squab is to be tried in small quantity. Cereals are being taken with milk each day. Water has been and is being pushed to toleration.

Diagnosis: M. M. R.

**SYPHILIS OF THE LUNGS.**

BY

MAX GREENWALD, M.D.

(Read before the New York County Homœopathic Medical Society.)

OBSERVATIONS in the treatment of advanced pulmonary tuberculosis in the wards of the Metropolitan Hospital and certain factors noted, created my interest in studying pulmonary syphilis in its various phases and forms. I offer this as my excuse for this paper.

While pulmonary syphilis is not so common as we are led to believe, still the condition occurs frequently enough to deserve watching, especially so in suspected cases of pulmonary tuberculosis with repeatedly negative sputa. There is no doubt a number of cases will respond to antisyphilitic treatment resulting in a cure of symptoms, and a change in the Roentgenographic picture.

The pathological changes found in the above condition are gummata, which occupy the lower lobes, as a rule. These may and do at times go on to cavity formation; then again the pathology may be of a fibrotic character. It is this condition which so closely resembles the tubercular type of lung and may only be differentiated from the same by a possible absence of apical involvement, and sometimes an enlarged aorta. The white pneumonia described is really the fibrous type of pulmonary syphilis observed on the autopsy table. Bronchiectasis is also sometimes found in parts of the lungs.

Clinically we found the condition to be insidious. The chief symptom the patient complains of is dyspnoea, which is severe, and worse at night and out of proportion to the physical signs elicited; temperature is of little help as the syphilitic lung will often give a temperature, and do so more or less constantly. We have observed that flatness of the most dependent portion of the involved lung on percussion, is rather frequent and of importance. When this part is fluoroscoped there is an obliteration of the costo-phrenic angle on that side. This is probably due to the breaking down of a gumma.

As illustrative of previous findings it was my good fortune to see a case in consultation with Dr. G., which clearly demonstrated the above condition. M. M., colored, 38 years old, who gives a history of an initial lesion about five years

ago and having received antiluetic treatment. Three years later he presented himself for treatment for marked dyspnoea, abdominal distention.

On examination there was marked distention of the abdomen, scrotum and lower extremities. Cardiac and renal conditions were ruled out and cirrhosis of the liver of syphilitic origin was considered. He was accordingly treated by rest in bed, dehydration of tissues, restriction of fluids and sodium chloride and in view of his luetic history and positive blood findings he was put on anti-syphilitic treatment, consisting of inunctions, and later by mixed treatment to which he responded readily with a complete disappearance of his subjective and objective symptoms.

He was well until a year ago when he again came for treatment for marked dyspnoea. On examination by his physician his left chest cavity was found to be filled up with fluid. He was again put on the same form of treatment to which he again responded.

At this time he was referred to me for examination. Examination of the chest showed heart sounds normal, with the exception of a definitely accentuated aortic second sound. Left lung posteriorly gave definite change in voice and breath sounds, flatness over dependent portion and distant breath sounds. On fluroscopy an obliteration of costo-phrenic angle. Some shadows observed in left lung lower lobe. The aorta was rather prominent, somewhat enlarged. The X-ray plate also presented very interesting findings. The aorta was enlarged and the heart bordering on the aortic type of heart in contour. The left chest showed an obliteration of costo phrenic angle. Three definite rounded masses or tumors, discrete and not coalescent, were noted in left lower lobe. The right side showed considerable bronchial thickening confined to the hilus. The fact that these tumor masses do not coalesce, the unilateral position they occupied, and the prominent aorta presented to me a typical picture from the roentenographic standpoint of pulmonary syphilis.

The subsequent plate taken on this patient after anti-syphilitic treatment (three months) shows the tumor masses have disappeared and the left costo phrenic angle to be clear. In fact, the entire chest seemed to be clear. The patient showed no subjective or objective symptoms. I have both



plates here this evening and will be pleased to have the roentgenologists present discuss them.

While the above case probably presents a more or less typical case of pulmonary syphilis it is the element of syphilis which may be present, associated with pulmonary tuberculosis, that is of great interest. As illustrative of above: Thirty-nine cases of pulmonary tuberculosis from the wards of the Metropolitan Hospital were examined and studied. In six of these a positive four plus Wassermann was obtained. The following histories in brief were obtained:

C. U., age 40, denies lues. Physical signs of those of a fibrosis of the lung.

J. M., age 40, male, gives no history of lues. Lung showed at the hilus a fibrocaseous type of tuberculosis.

C. S., age 42, male, history of initial lesion at age of 18 years. Has been ill for one year.

M. H., aged 34, denies lues. Lungs show a fibrosis of long duration.

J. K., age 50, gives history of lues 36 years ago. Presents a fibrosis on physical examination. A positive sputum has not been obtained.

F. C., age 52, gives a history of lues 20 years ago. Presents a fibrous type of tuberculosis. Coughed for years and never knew that he had lung trouble until present time.

These patients seemed to be well nourished and rather well developed. The X-ray findings are those of a fibrosis with the exception of one which shows a fibrocaseous tuberculosis with cavity formation. When these patients were put on tincture of iodine treatment, *i. e.*, 20 drops *t. i. d.*, they gained in weight and their subjective symptoms improved. I believe this tends to refute the old accepted idea that syphilis, when complicating a pulmonary tuberculosis, increases the severity of the condition. My intentions have been to give only my personal findings.

#### SUMMARY.

1. A Wassermann should be taken in cases of all pulmonary tuberculosis that have no positive sputa.
2. A co-existing syphilis does not necessarily increase the severity of pulmonary tuberculosis.
3. These cases do well under tincture of iodine or any

other anti-syphilitic treatment. Therefore, in doubtful cases, it is advisable to give the therapeutic test.

4. The recognized fact that syphilitic lungs do clear up under treatment leaving nothing definite but fibrous tissue, may account for lack of diagnoses of syphilitic lungs made upon autopsy.

5. X-ray of the syphilitic chest may show gummata, usually in lower lobe, unilateral obliteration of costophrenic angle on affected side. The aorta may be enlarged.

6. The well nourished and well preserved consumptive, in the absence of a positive sputum, to quote one observer, may be syphilitic.

I want to thank Dr. Silver, of the house staff of the Metropolitan Hospital, for his valuable assistance in selecting of cases and histories.

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**ADDRESS DELIVERED BEFORE THE GRADUATING CLASS OF HAHNEMANN MEDICAL COLLEGE, PHILADELPHIA, JUNE 5, 1920.**

BY

HON. SIMEON D. FESS.

Chairman of Committee on Education, House of Representatives,  
Washington, D. C.

THE progress of a nation essentially depends upon its brain. The value of its brawn will be in the proportion that it is directed by its brain. Mediocrity is a popular slogan in a campaign for votes, but it cannot take the place of superior excellency lifted above the rank of mediocrity by a long season of sacrifice and arduous training. The effort to exalt brawn above brain upon the claim that it is in the interest of many, cannot succeed. No nation can endure which ignores the value of mental development whether it be in rank in a community or appreciation in the scale of compensation.

The most significant as well as unsettling sign of the times is the seeming abandonment of our former appreciation of great accomplishments. It has been the mark of our time and especially of the American people to idolize achievement. It explains our universal interest in all contests, no matter of what character. The one who can put it over, whether on the athletic field, on the race course, in the box or on the field of

battle we have always admired if not worshipped—the one who succeeds. This national passion has passed into a proverb, “Nothing succeeds like success.” The country worships leadership, whether in the world of profession, of invention and discovery, or in business.

Each decade was marked by its leaders in reform whether religious, political or social. In fact the brilliant pages of our history are those which detail the work of the country's leaders; the Beechers, the Waylands and Brooks in religion; the Washingtons, the Lincolns and Roosevelts in politics; the Emersons, the Lowells and the Whittiers in Literature; the Warrens, the Harrises and the Maxwells in education; the Morses, the Bells and the Edisons in invention; the Hills, the Harrimans and the Cassatts in transportation; the Rockefellers, the Carnegies and the McCormicks in business; and thousands of others in various lines of achievement. These and men like them supply most of the nation's regard and admiration.

But at the present moment achievement seems to be in the discount. The impossibility of maintaining an absolute equality among men in any country, much less in a country where the freest opportunity is afforded to make the most out of one's ability, there are bound to be graduations. The man of rare ability amidst boundless opportunities for the play of that ability will inevitably climb above his fellow possessed of less ability, although surrounded by the same opportunities. Edison was not the only man amid the forces upon which he worked his way to his high rank. The same is true of every other person whose achievement placed him in a class of the few.

It is also an error to account for this accomplishment at the expense of others. Success is not the measure of unfair advantage taken of others. No doubt many have achieved in business by unfair and inequitable methods. Some cases are known and conceded. But it is vicious to conclude that since my neighbor succeeded, and I did not, that he was dishonest, because I was honest.

It is just as vicious for the welfare of the world to assume that we must produce equality to insure justice. The very genius of American greatness is not only equal opportunity under the law, but also the assurance of protection in personal rights so long as they do not interfere with the rights of



others. The assurance of the enjoyment of the fruits of one's toil and effort and the unhindered progress of one's success in the application of his ability to achievement is the one marked incentive which has distinguished this from all other countries in the world.

Any effort to hold all down to the deadening level of the average, if not to the lowest, is blighting. The present effort to level all up without regard to energy, application or ability, and thus repudiate the ambition to excel, is a reversal of all laws of progress, and must inevitably result in disaster. This dangerous possibility is made more ominous because it feeds upon a vicious principle. It accounts for the vast gradations of human conditions upon the basis of unjust advantage seized upon by the few against the many. It refuses to admire and applaud the individual of a community who, by the price of sacrifice and industry, advances beyond his fellows who decline to pay the price, but rather condemns him as taking some unseen advantage, else he could not have advanced. The remedy proposed is various. In Russia it is the abolition of all private property, the destruction of the employing class, the nationalization of all industries and of all professions, where all enterprise will be conducted without profit, for the benefit of all alike. This is now being tried out in Soviet Russia.

In this country the open proponents thus far have not gotten much favor, as the I. W. W. and Communist Associations are not in great favor. The most sinister suggestion is the rapid progress of recent years within the various labor organizations. Their success is shown in the radical utterances of such men as Mr. Gompers, until recently looked upon as a safe labor leader, but who for reasons not difficult to explain, has become so radical that he does not hesitate to give command to Congress, and openly notify committees of that body that such and such laws must not be enacted because they would not be obeyed.

He also assures the radical role of publishing his dictum stating who shall and who shall not be elected to Congress, viz., only those who have obeyed, or will promise to obey, his decrees. This reveals a second serious danger which the American people must meet. It is the effort of group control of the Government. This group control at once becomes dangerous because it is possible. It is based upon the promise to

run the Government in the interest of the group, in which all the group will greatly benefit beyond what can be realized without it. This promise has a tendency to solidify the group and follow the leader.

It also is dangerous because it promises to supersede a system of government which is declared by these agitators to be run for the few, by their system which they declare is run for the many. Upon this assumption they indict the man of success as a favorite and a man of failure as a victim of a bad system of government.

They propose to change it, and adopt a system which will repudiate the equality under the law, but which will insure equality by force of law. The former, they declare, and quite properly, must result in wide gradations of human conditions where we will have the high and the low, the latter they declare will produce a condition of equality where we will have a level upon which all will be equal, with none above, nor below.

This moment we have many proposals, both official and unofficial, backed by great groups, some of them militant, making such demands in the name of public welfare. This will account for the general attitude of great groups to cry down what we have been pleased to call examples of American achievement.

It will account for the organized and successful effort to forbid efficiency methods employed in Government work. It explains why we are constantly drifting to less efficiency and greater cost, instead of greater efficiency and less cost, which, until recently, was the slogan of all America, and which is the very foundation stone of our rank among the nations of the earth.

This changing world so completely reverses all that has been so fundamental in America and American institutions, that it embarrasses one who comes before an audience like this to talk upon the claims of our times upon the professionally trained men and women of the country.

Since the days of our nation's birth we have been crying exclusion. We have been holding aloft the possibility of achievement and stimulating an exalted ambition to climb the ladder to the very topmost round. We have extolled that possibility as justifiable and a laudable ambition. It is what has enacted our compulsory school laws; it is what has built

our colleges and universities; it is what has organized our industries. In a word, it is the very foundation of our position in the world today.

In spite of the ominous strides this cult is making; in spite of the response made to it in our legislative halls; in spite of this outcry against our educational institutions, or rather, their product, I am bound to say to you who receive today your commissions which enable you to do what the mass of us dare not do under the law, unless we qualify, that this crusade against our system of government and institutions will be shortlived if our people will but awake to its real meaning before it is too late. It may be accepted for a time, but not long. We have just passed through a short season when our nation was put to the supreme test. The war which claimed our finest talent was an excellent object lesson of the value placed upon ability. There was not a man nor a woman of superior talent in America who was not called to assistance of the nation in the hour of her greatest need. The only person who could not be placed was he who had no particular talent. The nation's greatest need was superior ability. The war was the best possible comment upon the value of training.

The Rev. T. Dewitt Talmidge used to say that every thousand years a new leaf of the history of civilization is turned. The educational statesman says that each century is marked by its intellectual dominant ideas as expressed by the leaders of thought. The eighteenth century was dominated by authority. The great leaders were of religious thought, and their works were theological. The nineteenth century was dominated by opinion and the leaders were of protest rather than advocacy, and their works became more or less political rather than religious. During this period there was general unrest among peoples over greater participation in governments. It was marked by numerous changes in forms of government throughout the world. Its authority was superseded by independent opinion, so was the latter rapidly superseded by a passion for achievement.

This trade-mark of modern progress was due to at least two great events; among others, the establishment of the Government of the United States upon the basis of equal opportunity for all men. This principle was fundamentally announced in the Declaration of Independence which was the announcement of a well defined conviction, the result of cen-



turies of struggle in the old world. It was made possible by a new world settled by Europe's best coming to America because denied rights at home. Here was the training ground of self-government in which equal opportunity under the law was fundamental. Separated from the old world by the barrier of sea, a choice portion of the earth's resources of climate, soil and mineral wealth was settled by a picked people of Europe who erected the structure of the American Republic upon the principles of the Declaration of Independence and inaugurated the "government of the people, by the people and for the people" under a federal constitution pronounced by the finest British mind as "the most wonderful instrument ever stricken off by the brain or purpose of man at any one time."

The growth of this Republic, which in one century has become the most powerful of all governments, reveals achievement as its dominant note. During the century and a quarter of our national history there has grown up under the Constitution the most composite population in the world. It is the most prosperous people upon the globe. It is the happiest people, enjoying larger liberties, exercising greater influence man to man than any government in the world. It has made greater use of its powers and abilities and greater use of its varied facilities for the general welfare of its people; it has permitted less suffering by taking better care of its unfortunates.

All this it has done under our system of equal opportunity under the law. We cannot afford to look disinterestedly upon the attempt to abandon our fundamental principles, on behalf of some foreign infusion which is presented to us from whatever source or by whatever leader. We must guard against allowing our nation to become the training ground of those who strive to overthrow our institutions.

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END RESULTS OF SOME FOCAL INFECTIONS.—Fontaine, after presenting several clinical reports with comments, offers the following conclusion: While this report is necessarily brief, he feels that it is sufficiently convincing to prove that often such conditions as pain, fever, headache, etc., are directly traceable to focal infections, and that the most effective measure for relief is complete eradication or a cure.—*Journ. of the Amer. Med. Association*, June 12, 1920.

## EDITORIAL

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### NATIONAL HOMŒOPATHIC CLINIC DAY.

At a recent meeting of the New York State Homœopathic Medical Society, the President, Dr. Roy Upham, proposed as a means of bringing the homœopathic hospitals of the country before the profession and the public that we establish a national homœopathic clinic day, on which occasion clinics shall be held in all of our hospitals, barring none. At first sight, the advantage of the plan appears to be largely sentimental, but as one thinks of it more and more the better does it appear to be, and the greater seems to be its sphere of utility viewed from any standpoint we may. In fact the practical advantages predominate.

At the start, one fundamental fact must be kept in mind. The occasion is to be known as THE NATIONAL HOMŒOPATHIC CLINIC DAY, which tells the whole story, or should do so. Under no circumstances should we get away from the fundamental idea indicated by the title. We say this because we understand that some enthusiastic advocates have suggested that the various State Societies change their times and places of meetings to co-ordinate with the hospital clinics, a suggestion which, to our mind, defeats absolutely the idea of the clinic day, an idea that every homœopathic hospital, great or small, located in village or in metropolis, shall hold at least two hours of clinic service. If this idea should be adopted in New York State, for example, with hospitals located in New York, Brooklyn, Rochester, Buffalo, Syracuse, Albany, Utica, and other places, to say nothing of special hospitals in Middletown, Gowanda, Liberty, and elsewhere, it is plain that the institutions in all but one of the cities named will be neglected. Likewise the staffs of said hospitals cannot be on hand on "Clinic Day" for they should be at the State Society meeting. The idea should die a-borning.

The "Clinic Day" impresses us as an especially good thing for our smaller hospitals. It will lead the medical staffs to attach to themselves individually a greater sense of importance, which is of itself conducive to improved work. The

preparation of a clinic by one not engaged regularly in teaching work involves considerable thought and reading. The ambitious staff doctor knowing that the eyes of the profession are fixed upon him will not neglect this preparation. It is more than possible that men who have had ambitions for clinical teaching and have a natural talent for such work, but who have been deterred from entering into it by lack of opportunity, may loom up in prominence at once as teachers of men. *The National Homœopathic Clinic Day may, therefore, develop a class of teachers that will replace some of the weaker ones in the colleges.* Or some small hospital may secure prominence, develop into a large institution and become a Mecca for the profession. This sounds visionary, but it has its possibilities.

Local pride will lead to active local interest in the project. Managers of hospitals can be made to see that the field of the hospital's utility is enlarged. The public press is likely to take the matter up; and in this, as in other schemes, the press is a power for good.

We have also thought that the hospital clinic day is capable of developing the county society. While we have objected to making State Society meetings and Clinic Day contemporaneous, we think that such an arrangement between County Society and Clinic Day is of distinct advantage.

The hospitals in the large cities, especially in the teaching centers, are likely to attract the largest audiences, a large part of which may be drafted from distant points. Under such circumstances, it may prove to be a distinct advantage to stretch the clinic service over a period of two or even of three days to compensate the physicians who attend for their long travel.

A big idea like the hospital clinic day is not likely to attain its maximum success on the first occasion. Mistakes are to be expected. It has been truly said that the "man who makes no mistakes does not make anything else." All interested must enter into the plan with enthusiasm, voicing no objections whatever, but holding to a determination to do his best.

Let each hospital resolve to hold a clinic on October 19, 1920 and then hold the very best clinic of which its staff is capable. And when the day is over, let each one take account of the day, study its triumphs and its disappointments, and reach conclusions whereby the service will be improved greatly for October 19, 1921.



### THE DEARTH OF NURSES AND THE DUTY OF THE PROFESSION.

THE war and the influenza pandemic taught the profession and the public their dependence upon nurses. Indeed, it may well be said that fully 50 per cent. of the mortality during the epidemic was directly traceable to the dearth of nurses. Under ordinary circumstances, the supply fell far short of the demand. With many of the nurses in the cantonments and on the battle fronts of Europe, the comparatively few that remained at home were decidedly inadequate. It was hoped that with the ending of the war, the nurse famine would no longer exist. New industrial conditions arose. Women had been drafted into numerous occupations hitherto followed by men only, and drew good pay, far more in fact than ever before had been their lot. Young women in fewer numbers applied to the training schools for nurses, and each year has added to the famine, until at the present time, there is scarcely a hospital in the country that is working on 75 per cent. of its normal force.

Something must be done at once to relieve the situation, and there is no one whose efforts in this particular will be more efficient than those of the physician, whose duty it now is to do all that is within his power to induce suitable young women to enter the training schools of our hospitals.

The profession of nursing offers to the adaptable young woman a brilliant future. The demand for graduate nurses is such that the registries throughout the country cannot begin to fill half the applications, and it is safe to say that nurses are securing better salaries than those of any other vocation open to women.

The character of the nurse's training is such that we are safe in saying that she is a 100 per cent. finer and broader woman as a result.

The requirements as to preliminary education are such that none but women of refinement and education can be accepted by the training schools. This fact secures for the pupil nurses an environment that must be congenial.

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### AN ADDITION TO BACTERIOLOGY.

WITH the advent of the microscope, bacteria were discovered and their relationship to disease and other processes

established. Bacteria have long been considered very simple forms of life and while variations in their morphology and biology have been recognized, it remained for Mellon, along with others in the last decade, to point out how complex even the simple forms of life may be.

Mellon, in the *American Journal of Medical Sciences*, June, 1920, page 874, has an interesting article titled, "Life Cycles of the Bacteria and Their Possible Relation to Pathology." While it is impossible in a short space to give all the details of the work leading to the conclusions of Mellon and others whom he mentions, it may briefly be stated that these men are of the opinion that bacteria—certain ones at least—pass through life cycles which in some way influence their relationship toward disease.

Several micro-organisms have been shown under special conditions, to present budding, filaments and branches, and we are safe in assuming that the ability of these men is such that their findings are not artefacts. These changes, according to these observers, are not those of involution as is generally understood; but are natural progressive changes. To draw a vague parallel; micro-organisms, in this new light, may be compared with butterflies, in that they pass through definite well-recognized stages in which the anatomy and physiology may be said to be different. The life cycles of certain insects are well-known, and it seems almost unbelievable that with all the work done in bacteriology, definite cyclic changes in bacteria have not been recognized long before this.

The theory of evolution furnishes much that is fascinating and has greatly stimulated biological research. Under changing conditions of life organic beings present individual differences in almost every part of their structure. Briefly, Darwin supposes that useful variations and individuals thus characterized will have the best chance of being preserved in the struggle for life, and "From the strong principles of inheritance these will tend to produce offspring similarly characterized." These changes lead to the improvement of each creature in its relationship to its conditions of life and consequently in most cases to what must be regarded as an advance in organization.

Wade and Manalang (*Journal of Experimental Medicine*, January, 1920, page 95) in an article titled, "Fungus Developmental Growth Forms of *Bacillus Influenzæ*," have suc-

ceeded in producing certain changes with the B. Influenzæ, similar to those produced by Mellon with diphtheroids. Wade and Manalang were unable to perpetuate the fungoid growth of B. Influenzæ in subsequent cultures. That is to say, the aberrant forms seemed unable to reproduce themselves. With the theory of evolution in mind, this to us, suggests that perhaps these variations in form are of a retrogressive nature. It may be said, however, that evolutionary changes require longer than a few generations to show themselves. However, as Mellon suggests and points out in his article, the metamorphosis of bacteria may be responsible for filterable viruses, biological variations of bacteria and the nature of some diseases which manifest themselves by periods of incubation and remissions.

This work is interesting from many angles, to say nothing of the influence, either transient or permanent, upon medicine. "Truth, whether in or out of fashion, is the measure of knowledge."

J. G. W.

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#### THE BABY'S FOOD DURING TRAVELING.

At this season the question of taking the baby on a journey frequently comes up for discussion and the advisability of taking a trip of a day or longer duration rests largely upon whether the baby can be safely fed during this time. Naturally in cases in which an infant has been fed upon complicated formulæ which must be made fresh daily and which must be kept constantly on ice, some difficulty will be encountered. Also the question of a change of milk must be considered. The advantages of a supply of certified milk, which may have to be abandoned if the proposed trip is undertaken naturally weigh heavily in any argument against taking the baby away from such a supply. There are, however, instances in which a change of location is imperative; also, a change of climate may outweigh in its advantage to the child the consideration of the milk supply. Since it is unquestionably safer to feed boiled milk during the hot summer months, even when certified milk can be obtained, any good, clean milk, properly sterilized, will answer as a satisfactory food at this time of year. Fresh, clean milk which can with safety be fed raw is, of course, the ideal infant food; however, many babies do



not thrive as well on raw as on boiled milk and in extremely hot weather we cannot afford to take chances with even the best of milk.

Condensed milk used to be the popular substitute for fresh milk and was especially recommended for traveling. Of recent years milk has been successfully dehydrated so that it can now be obtained in the form of a powder. Dry milk preparations, which represent powdered milk alone without the addition of carbohydrates in the form of sugar of milk, malt sugar, etc., are the most practical substitutes for fresh milk and give the best clinical results. Unlike many proprietary foods, their use does not appear to lead to nutritional disturbances and they can be fed over a period of months without incurring the danger of the development of scurvy. C. S. R.

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TRANSIENT AND PAROXYSMAL AURICULAR FIBRILLATION.—V. R. Mason has made a study of eighteen cases which come under the above title, pre-facing his report of clinical histories by the following remarks: There is a large group of cases presenting a fairly typical and uniform clinical picture in which the attacks of auricular fibrillation recurring at periods throughout many years, are the most striking feature. The patient is usually an elderly individual, whose symptoms consist of breathlessness and palpitation, occurring in paroxysms, either during physical exertion, mental strain or at times even during sleep. Between the attacks there are relatively few symptoms referable to the cardiac system, although usually any unaccustomed exertion is followed by slight dyspnea. The patient seeks advice of a physician either on account of the heart attacks or because of increased breathlessness on exertion. Physical examination usually reveals the presence of increased cardiac dullness, some peripheral arterio-sclerosis, and occasionally hypertension. Subsidiary findings such as chronic bronchitis and emphysema or a mild grade of renal disease may be present.

One is impressed that the clinical picture is that of mild or, of course, eventually of more severe myocardial weakness in which the paroxysms of auricular fibrillation are prone to occur after any unusual demand on the heart.

Transient auricular fibrillation is a rare condition due to the action of certain poisons on the heart muscle, or perhaps on the nervous mechanism of the heart. Until the essential cause of auricular fibrillation is known, the pathological condition necessary for its production must remain the subject of speculation.

A few patients with endocardial lesions have shown attacks of atrial fibrillation. In them the arrhythmia is one more sign of myocardial insufficiency, and usually becomes permanent long before death. Such patients, as a rule, are simply passing through a prolonged transition period.—*Johns Hopkins Hospital Bulletin*, May, 1920.

## GLEANINGS

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### MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

BACTERIOLOGIC DATA ON THE EPIDEMIOLOGY OF RESPIRATORY DISEASES IN THE ARMY.—Nichols (*Jour. Lab. and Clin. Med.*, May, 1920, p. 502) experimented to determine the most probable method of spread of respiratory diseases. Diseases may be spread directly, or air borne; or they may be spread indirectly, object borne. Lynch and Cummings pointed out that respiratory diseases were spread by "hand to mouth" method and by contaminated dish water in which the soldiers placed their hands while washing their mess kits. Nichols found that streptococci disappeared from the hands in a much shorter time than was supposed and that in a room, droplets containing streptococci remained in the air for a long time. With streptococci as the test organisms it was found that dish water did not favor their spread; while colon was little if at all affected by the dish water. The author is of the opinion that while intestinal infections may be spread by means of contaminated dish water, respiratory diseases are most likely spread by infected droplets floating around in the air.

VENOUS THROMBOSIS, PULMONARY INFARCTION AND EMBOLISM FOLLOWING GYNCOLOGICAL OPERATIONS.—Hampton and Lawrence have made an extensive study of a large series of cases covering the above lesions at the Johns Hopkins Hospital. As to thrombo-phlebitis or peripheral thrombosis, one point was prominent in the early clinical histories of all the cases, namely, that the temperature did not follow the usual course observed in cases that follow an ideal course, in that it remained above normal after the first week. The pyrexia persists as a definite rise of temperature from the time of operation until the appearance of pain and swelling. It is seldom high, usually ranging between 99 degrees and 100 degrees. The pulse usually remains low, the pulse curve either accompanying or falling below the temperature curve. The diagnostic symptoms include pain, which may be severe, and in rare cases, tenderness along the course of the femoral vein. The tenderness sometimes precedes the spontaneous pain. Swelling follows promptly and may be pronounced. Elevation of the surface temperature is common. Redness over the course of the vein is rather unusual; the limb occasionally becomes cyanotic. Decided rise of temperature does not take place until the initial symptom of pain is evident. Most of the thromboses occurred during the second and third weeks of convalescence, the most common period being at the end of the second week. Swelling of the leg is likely to persist long after convalescence is established. The most serious complications of thrombo-

phlebitis are pulmonary, and include pulmonary infarcts and pulmonary embolism.

*Clinical Picture of Pulmonary Infarction.*—Of the symptoms, pain on breathing is the outstanding feature. It is sudden in onset, usually very severe, making the taking of a deep breath almost impossible. It is usually localized along the costal margin or over the lower ribs, usually in the axilla or below the scapula. Compared with pain, cough is rather a minor symptom. In this respect infarction differs from all other types of post-operative pulmonary complications. Shortness of breath was present in 54 per cent. of the cases. It is usually not of the gasping air-hunger type found in pulmonary embolism or severe secondary anaemia. The increased respiratory frequency seems to be due chiefly to the inability of the patient to take a full inspiration without pain, and the substitution of a number of shallow respiratory movements. This symptom occurs on the day of infarction along with the pain. Hæmotysis is present in 34 per cent. of the cases. Collapse and cyanosis are not frequent unless the condition of the patient is extremely poor or the infarction grave. Anxiety and fear of death are not infrequent. Of the physical signs, the presence of a friction rub is the most characteristic (75 per cent.). Rales have been found in about the same proportion of cases, while percussion dullness is somewhat less frequent (63 per cent.). In a typical case, the temperature commences to drop on the fourth or fifth day, and in ten days it is either normal or nearly so, and the symptoms have entirely cleared up. Careful examination of the chest may show a residuum of only a few physical signs. An elevation of temperature persisting over a period of two weeks usually means a complication. These include lung abscess, broncho-pneumonia, pulmonary gangrene, miliary abscesses and septicæmia. Repetition of attacks of infarction are observed at times. In the intervals the temperature usually reaches normal and symptoms disappear. Embolism may supervene upon thrombosis. The most serious cases of infarction are those developing during the first week.

The authors remark that the diagnosis of pulmonary infarction at the Hopkins Clinic has been poor, only 10 per cent. of the cases being recognized. The explanation for this poor showing is found in that too much attention has been paid to the physical findings and too little attention to the entire clinical picture. The leucocyte count is usually between 12,000 and 15,000 and is of little help in the diagnosis. The conditions from which infarction must be differentiated include pleurisy, pneumonia, pulmonary tuberculosis, bronchitis, empyema, gangrene of the lung, pulmonary abscess and subdiaphragmatic abscess.—*Johns Hopkins Bulletin*, April, 1920.

LOEWI'S ADRENAL MYDRIASIS AS A SIGN OF PANCREATIC INSUFFICIENCY. —Cockroft reports two cases which, as far as such a limited experience will go, confirms the value of the Loewi reaction as a sign of pancreatic disease. The test consists in the instillation of two drops of adrenalin solution, 1:1000 in one eye, the other eye serving as the control. In the presence of pancreatic disease the pupil dilates under the influence of the adrenalin in the course of one hour. He also makes mention of three additional cases in which the reaction was negative and in which, on autopsy, the pancreas was found healthy.—*British Medical Journal*, May 15, 1920.



## PEDIATRICS

Conducted by C. S. RAUE, M.D.

INFLUENZA IN CHILDREN.—MacCarthy considers that next to the pneumonias, otitis media, usually unilateral, has been the most frequent of the complications and sequelae of influenza. Other conditions associated with the following influenza were: Adenitis, tonsillitis, epistaxis, neuritis, nephritis and meningeal symptoms. MacCarthy believes that complications and after-effects in children in very many cases were the result of poor nutrition, not being put to bed early enough, and allowing them to get out of bed too soon.

Green writes of the treatment of influenza in children and gives the following homœopathic remedies with their indications:

*Aconite*, despite its wide applicability to febrile conditions, seemed infrequently indicated. At times, very early in the disease, it was the perfect simillimum, at other times it did splendid work in cases that suddenly developed an excessively high temperature after the disease had progressed moderately for a number of days. Influenza patients do not commonly have the thirst and restlessness that are uniformly present in the aconite case.

*Antimonium arsenicosum*, a truly wonderful remedy in broncho-pneumonia was used very frequently with excellent results.

*Antimonium tartaricum* was also used frequently in the cases which had pneumonia or bronchitis. The rattling of mucus, drowsiness, debility and sweat—all constant characteristics of *antimonium tartaricum*—were among the commonest of influenza symptoms.

*Arsenicum album* came in but seldom, and then only in advanced, severe cases.

*Arsenicum iodid*, third decimal, seemed so often applicable at the beginning of convalescence that its use became empirical and routine.

*Belladonna* was often indicated for nervous symptoms, the rather common neuralgic pains, and particularly for the typical pharyngitis so many influenza patients presented early in the disease.

*Bryonia* proved of great value, especially in pneumonias in which the lobar type was simulated and the characteristic pleuritic pain was in evidence.

*Ferrum phosphoricum*, in the author's experience, was the most important remedy of all. Besides its indications in uncomplicated influenza, its provings give a perfect picture of the unusual type of broncho-pneumonic. Case after case that seemed almost hopeless responded to its beneficent influence. It was of very great value also in controlling the severe epistaxis so often encountered. Indeed, if I was confined to one remedy in the treatment of influenza as I saw it during the past year, I should choose *ferrum phosphoricum*.

*Gelsemium* is another remedy entitled to our highest consideration. With its aching pains, its drowsiness, its fever without thirst, its coryza, its weak, slow pulse, its muscular weakness, it presents a perfect picture of what we commonly meet in influenza. And yet—and in this I particularly want to hear the experience of others—I could not obtain the

results with gelsemium in children that I could with adults. There may be some personal prejudice about this, for I have long been of the opinion that for some reason children do not ordinarily respond to gelsemium as readily as do adults.

*Ipecacuanha*, while its respiratory symptoms were often present, frequently had to be introduced empirically to control nausea and vomiting.

*Phosphorus*, upon so common tracheolaryngeal symptoms, was prescribed very often. In some cases the rapidity with which it cleared up persistent, dry, irritating coughs seemed almost miraculous.

*Rumex* is another with a special affinity for the trachea and larynx which occasionally gave excellent results.

*Sanguinaria*, as ever, proved of great service in pneumonia when there was great dyspnea and evident need of an expectorant.

*Spongia* was used to good advantage in several cases in which the children developed croup as a complication.

For sedatives, *chamomilla* or *magnesium phosphate* were occasionally given in addition to other homœopathic remedies, but in no case coal tar derivatives or opiates.—*The Journal of the American Institute of Homocopathy*, May, 1920.

ORANGE JUICE.—Byfield, Daniels and Loughlin. After extensive experimentation with diets with and without orange juice, the authors conclude that this fruit juice contains a relatively large amount of the antineuritic vitamin. It was found also that the growth stimulating influence of orange juice appears to be due to the antineuritic vitamin contained therein, and orange juice from which the antineuritic vitamin is removed by absorption does not stimulate growth. This would seem to indicate that the antiscorbutic vitamin lacks growth stimulating properties.—*American Journal of Diseases of Children*, May, 1920.

ARTIFICIAL INFANT FEEDING.—Ostheimer urges us to "give the baby enough." He says that the average young infant will always take from three ounces up at each feeding, and can digest it well. Within one week most babies can take four ounces at each feeding; provided, that the interval between feeding is three hours or longer. Just as soon as the baby can take four ounces well, digest it well and show no symptoms, he should be given another half ounce at each feeding; and when he takes that well, still another half ounce may be added to the mixture. The author believes that as soon as the baby has four or more opposing teeth, he is physiologically ready for semi-solid food. By the age of nine or ten months, then, the modern infant ought to be ready and able to digest undiluted cow's milk, and very soon after that cereals, potatoes, stale bread, toast or zwieback, either hard or soaked in milk; stewed fruits, and a soft boiled egg.—*American Journal of Diseases of Children*, May, 1920.

THE SUBOXIDATION SYNDROME IN CHILDHOOD.—Kerley and Berman. A child with the suboxidation syndrome is one whose physical functions are habitually below the normal. The parents of the children are nearly always those who have been occupied with intellectual pursuits and not by manual labor. The child is usually underweight and there is a lowered endurance with mental precocity. A striking feature is a dryness of the

skin with a tendency to erythema and mild eczema. The patients are very sensitive to cold weather and are moderately anemic; the appetite is often capricious and constipation is the rule. There is usually a marked tendency to repeated attacks of afebrile rhinitis and bronchitis throughout the winter. Removal of tonsils and adenoids has been of little or no benefit. Also there is the tendency to attacks of recurrent vomiting. All of these children have a defective metabolism for the soluble carbohydrates and for the hydrocarbons, particularly for cow's milk fat and a noteworthy feature in nearly every case has been the improvement in appetite and the marked gain in weight upon removal from a diet of the fats and sugars. The urine contains acetone which is increased in amount during a vomiting attack. Most of these cases show a hyperglycemia averaging 163 mg. of glucose per 100 c.c. of blood.—*Journal of the American Medical Association*, May 1, 1920.

THE HYPERTONIC INFANT; THE CURATIVE ACTION OF ATROPIN ON CERTAIN OF ITS MANIFESTATIONS.—Sidney V. Haas, M.D., summarizes his study of this condition as follows: "The hypertonic infant is a definite clinical entity. It is characterized by hypertonicity of all the skeletal muscles, as shown by the ability to raise the head and grasp objects even in the early days of life, and by general spasticity. The hollow viscera show increased activity of their smooth muscle fibers. This expresses itself in the form of spasm involving practically every part of the digestive tube, and, depending on the region, presents the symptoms of colic, visible peristalsis, vomiting, constipation, or any combination of these. Accompanying these symptoms is marked psychic irritability, expressed by insomnia, general restlessness and crying. The hypertonic infant belongs to the spasmophilic group and presents the symptoms of vagotonia.

"Its recognition is of importance in this, that while presenting symptoms, in the main of disturbance of nutrition, food regulation alone does not correct the fault, whereas treatment by the drug atropin is followed by rapid subsidence of symptoms, the results being so prompt and regular as to constitute specific action. The tolerance for milk, which is usually low in these infants, is at once materially increased, so that a normal amount may be utilized—a condition quite opposed to that existing before the atropin was begun."—*Amer. Jour. of Diseases of Children*, May, 1918.

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## SURGERY

Conducted by J. DEAN ELLIOTT, M.E.

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THE SURGICAL TREATMENT OF EXOPHTHALMIC GOITER.—Crile describes the evolution of his system of treatment of exophthalmic goiter in a series of 1169 cases. The mortality rate fell from 16% to 1.1% in a recent series of 182 cases. The principal factors in his system of management are: 1. The differential diagnosis is greatly aided by the Goetsch test and metabolism determinations. 2. The operative procedures are graded according to the severity of the disease. 3. The inhalation anæsthetic is nitrous oxid-oxygen, which is administered with the patient in bed; the operation being performed either with the patient in bed or after his transportation, under anæsthesia, to the operating room. 4. In moderate cases the entire operation may be



completed at one seance. 5. In more severe cases the thyroid activity is diminished by a preliminary ligation with the patient in bed, under nitrous oxid-oxygen analgesia and local anæsthesia. 6. In extremely grave cases it may be necessary to diminish the thyroid activity by multiple steps—ligation of one vessel; ligation of the second vessel; partial lobectomy; complete lobectomy—allowing intervals of a month or more between these stages, the length of each interval being determined by the degree of physiologic adjustment. 7. If during the operation the pulse runs up beyond the safety point, the operation is halted, the wound dressed with flavine, and the operation completed after a day or two when conditions have again become safe. In some cases, even though the thyroid has been resected, it is advisable to dress the unsutured wound in flavine and make a delayed suture in bed the following day under analgesia. 8. In certain cases lobectomy is performed while the patient is in bed and under nitrous oxid analgesia and local anæsthesia. 9. Psychic control of the patient on the part of the surgeon, the interne, the anæsthetist, and the nurse is required throughout to diminish the intense drive. An associated regimen should be prescribed for the preoperative, inter-operative, and postoperative periods. The preoperative and the postoperative managements are of almost equal importance to that of the operation itself. 10. If, after the operation, the temperature becomes excessively high, with greatly increased pulse and respiration, the patient is packed promptly in ice. 11. To avoid the effects of too sudden a withdrawal of the thyroid secretion, thyroid extract is given the night before a lobectomy.

In this paper we have considered only the immediate surgical management of exophthalmic goiter. It should be noted, however, that the post-operative management of these cases is of equal importance. Because of the striking benefits which follow the operation, and in view of the fact that a comprehensive surgical control yields a mortality rate of 1.1% and excludes the rejection of any case on account of its gravity, we feel that the status of the surgical treatment of exophthalmic goiter is approaching the status of the surgical treatment of acute appendicitis.—*Surg. Gyn. & Obstet.*, January, 1920.

THE OCCURRENCE OF HYPOCHLORHYDRIA IN GALL-BLADDER DISEASE.—Contrary to the general belief that hyperchlorhydria is a finding in diseases of the gall-bladder, Fravel (*Amer. Jour. Med. Sc.*, April, 1920, p 512) has found that hypochlorhydria was the rule in 61 cases which he studied. He states that, "Of these 61 cases, 16 show an absence of free HCL, 45 show free HCL of less than 20, 11 come in the bounds of normal and only 5 cases show an increase of free HCL." The cases studied were carefully selected and those presenting any evidence of gastric or duodenal disease eliminated. The author suggests that, "hypo-acidity may be the result of loss of a hormone that is secreted by the normal gall-bladder, which loss inhibits the secretion of hydrochloric acid, or it may be due to a disturbance of intermediate chloride metabolism." The gastric symptoms associated with gall-bladder diseases may result from hypo as well as from hyper-acidity and the pain due to an increased intragastric pressure.

NEWER CONCEPTIONS OF THE PATHOGENESIS AND TREATMENT OF EMPYEMA.—Moschcowitz concludes a long article on this subject with:

1. Empyema in most instances results from the rupture of a small subpleural pulmonary abscess.

2. An empyema is the final stage of a process in which the first stage is a serous pleurisy and the second a seropurulent pleurisy. The latter is the so-called "formative" stage of an empyema.

3. The "formative" stage is unaccompanied by pleural adhesions. The stage of final empyema is always accompanied by adhesions.

4. The vast majority of empyemata are of the encapsulated variety. Very few occupy the entire pleural space.

5. Metastatic suppurations accompanying empyema are to be found rather as complications of the causative pneumonia than of the empyema.

6. The treatment of an empyema should be begun in the formative stage before the exudate has been converted into frank pus.

7. It is unwise to perform an operation in the formative stage. The mortality is terrific because the accompanying pneumonia is still in full bloom and, furthermore, because of the absence of adhesions there occurs a pneumothorax with "fluttering of the mediastinum" and consequent embarrassment of the heart action.

8. The best surgical procedure in the formative stage is repeated aspirations, done every twelve to twenty-four hours, in order to relieve the respiratory embarrassment due to the mechanical pressure of the rapidly accumulating fluid. In a few cases this measure is curative.

9. Feeding with a diet rich in calories is an important adjuvant in the treatment of the formative stage.

10. The treatment in the acute stage of an empyema consists in a simple intercostal thoractomy. This operation need not be considered an urgent one, and should be performed when the patient's condition is otherwise perfectly satisfactory. This is the so-called "late" operation.

11. Urgent thoractomy is indicated only in acute pyopneumothorax.

12. The Carrel-Dakin treatment, properly carried out, has proved of superlative value in the postoperative treatment of empyema and should be used in every case. There are no contraindications to its use.

13. The mortality of acute empyema by these methods is lower than that reported by other methods of treatment.

14. Empyema cavities heal by three methods: (a) By the formation and absorption of a sterile exudate; (b) by the formation and "absorption" of a closed pneumothorax; (c) by the "classical" method, i. e., the expansion of the lung and obliteration of the pleural cavity by adhesions.

15. "Chronic" cases of empyema may be defined as such which are not amenable to treatment by the Carrel-Dakin method.

16. "Chronic" empyema should not occur, or at least should become very rare, if the methods of treatment of acute empyema as formulated above are practiced.

17. Recurrences in empyema are usually the result of undue haste. The percentages of recurrences is less after the Carrel-Dakin method of treatment than after any other.

18. The vast majority of operations that have been devised for chronic empyema will have a very limited field of usefulness if the methods of treatment advocated above are carried out.—*American Journal of the Medical Sciences*, May, 1920.

## OPHTHALMOLOGY

Conducted by W. M. HILLEGAS, M.D.

**ALTERNATING PSEUDOSYNDROME.**—Under this title, Moreau reports a case of fracture of the skull accompanied by left hemiplegia, right incomplete facial paralysis with ptosis, right exophthalmos and immobile eyeball, slight conjunctival and palpebral ecchymosis, mydriasis, with complete loss of pupillary reaction and vision, and hemorrhage covering the nerve head. No loss of consciousness. Later there was loss of sensation of cornea and conjunctiva, with myosis, and doubtful reaction to light. The exophthalmos disappeared, and there was progressive amelioration of the immobility of the eyeball. The author believes that there was an antero-posterior fracture of the skull on the right side, terminating in the optic canal. A subdural hemorrhage by compression caused the left hemiplegia and entered into the sheath of the optic nerve causing the ocular symptoms.—*Ann. d'Ocul.* 1919—Abs. in *Amer. Jour. of Ophthal.*, May, 1920.

**VASCULAR KERATITIS.**—Bonnefon recalls that normally the cornea is a tissue entirely deprived of blood vessels. If blood vessels occur under pathologic conditions they may be either part of a process of attack or of defense. Scrofulous keratitis differs from phlyctenular keratitis in that the initial nodules, the phlyctenules, are absent, but instead an early vascularization indicates that the cornea is the seat of a pathologic process. This vascularization, associated with local and general symptoms of scrofula, will furnish the diagnosis. The affection left to itself progresses rapidly, with various alternation in the intensity of the painful symptoms. It ends in sclerosis if the vascularization is not arrested. This can readily be brought about, Bonnefon contends, by means of the galvano-cautery.—*Jour. de Medecine de Bordeaux*, April, 1920.

**HYSTERIC AMBLYOPIA.**—A great deal has been written about the ocular symptoms of hysteria and our knowledge of these symptoms is fairly complete: the contracted fields of vision, the good orientation in spite of the contracted fields, as shown by the patients moving about without running into and stumbling on things, the reversal of the color fields, the predilection for red, so that red is seen better than other colors, the areas of local anesthesia of skin and mucous membrane, especially on that half of the body corresponding to the eye with the greater amblyopia or more contracted field and the motor symptoms of ocular hysteria, spastic rather than paralytic.

Why then is the diagnosis of hysteria so often baffling? It is not simply because it must be made largely by exclusion, since it must be shown that no adequate ocular disease exists to produce the symptoms. It is not because the diagnosis has to rest on the way the ocular symptoms are accounted for. There is something more needed to make a positive diagnosis of hysteria than the presence of isolated symptoms, such as amblyopia without discoverable organic cause. Moreover, hysteria may exist in the presence of organic lesions adequate to produce many of the symptoms.

A better understanding of the nature of hysteria will help tremendously in elucidating ocular symptoms suspected of being hysteric, but about which there is uncertainty. The neuro-psychiatrists have thrown a flood of light on the nature of hysteria.

There is a close relationship between hysteria and malingering and we



shall be aided very much in differentiating them by acquiring a grasp of the psychology of the unconscious and the modern theories of hysteria. The hysteric reacts to an intolerable situation, of which he is not aware, by an adjustment which is unconscious. With the malingerer the intolerable situation and his reaction to it are both on the level of consciousness. He knows what he is doing and deliberately deceives. The hysteric has no idea that it is because he is executing a defense reaction to an intolerable situation that he is a victim of his symptoms.—Dr. Walter Lancaster in the *Amer. Jour. of Ophthalm.*, April, 1920.

**ETHYLHYDROCUPREIN POISONING.**—It is a well known fact that certain individuals have an unusual idiosyncrasy for quinin, or its salts, when they are taken internally. But poisoning by the small quantity that is absorbed through the conjunctiva in a state of acute inflammation, or from the overflow through the tear ducts into the nose, is exceedingly rare. Finnoff reports a case occurring in a young man, aged 23 years, who had a severe bilateral conjunctivitis. Stained smears of the secretion revealed the pneumococcus. Thirty-six hours after the first instillation of optochin (ethylhydrocuprein) which was used every two hours, the conjunctivitis became aggravated and the lids more swollen. A fine vesicular rash which resembled an urticaria appeared on the face and neck and on the back of the hands. The patient suffered with a severe headache and some ringing in the ears. He admitted to a susceptibility to quinin, and had developed symptoms several times after the administration of very small doses. The optochin was discontinued and a 10% solution of argyrol substituted, which was followed by rapid improvement of the conjunctivitis with a disappearance of the rash and headache.—*Amer. Jour. of Ophthalm.*, May, 1920.

**METHYL ALCOHOL POISONING.**—The need of calling attention to this subject is the more urgent because of certain clinical peculiarities of wood alcohol poisoning and blindness. The early period of intoxication is attended with no visual disturbances. The patient may become insensible and recover consciousness and get about again, without any impairment of vision. Or without losing consciousness, he may go several hours or days and seem to be largely recovered from the effects of the drug. Then he usually suffers severe gastro-intestinal irritation, cramps and vomiting, with rapid loss of sight. This may go on to complete blindness lasting for several days, and then the sight almost always begins to come back. Useful vision is regained, and improvement continues several weeks. Then the vision begins again to decline, and usually goes down until it is as bad as it was in the early part of the attack. But this second loss of vision is almost always permanent, and is not prevented or limited by any form of treatment that can then be resorted to. This clinical course is the most characteristic feature of wood alcohol poisoning.

The objective symptoms are not pathognomonic. In the end there is optic nerve atrophy; which may have the appearance of primary atrophy, but generally shows some blurring of the edge of the disc. But at the beginning the changes shown by the ophthalmoscope may not be striking. Swelling and edema of the nerve head may show neuritis, or may only give an appearance not very different from that often seen in eyestrain. Pallor of the disc and contraction of the blood-vessels develop very gradually, and are never so striking as in quinin amblyopia. The field of vision may show a large indefinite central scotoma early; and later always undergoes great irregular

and concentric narrowing; but these are not peculiar to this form of disease.

The prognosis is not absolutely bad for cases seen early, but it should always be guarded. We have to deal with a poison, the effects of which continue to develop for a long time after the taking of it into the system has stopped.

As to treatment, it should be remembered:—that it is always of utmost importance to get wood alcohol out of the system at the earliest possible moment. Unfortunately, the violent vomiting and purging, that mark many cases, occur after the poison has left the alimentary canal and is acting on the nerve centers. The hot pack, Turkish bath, pilocarpin sweats, free ingestion of water, are the promising means at our command to accomplish elimination. But these measures must be resorted to promptly, and pushed vigorously to the maximum compatible with safety.—Edward Jackson, M.D. Abs. from his editorial in the *Amer. Jour. of Ophthal.*, Feb., 1920.

## DERMATOLOGY

Conducted by RALPH BERNSTEIN, M. D., F. A. C. P.

**POST-INFLUENZAL ALOPECIA.**—The result of Samuel Ayers' study of twenty-four cases of post-influenzal alopecia shows that the condition makes its appearance probably two or three months after the onset of the influenza, but occasionally during convalescence. The alopecia is usually of the diffuse type, although in two of the cases studied the lesions were patchy, and, without a history of influenza, might have been diagnosed alopecia areata. Twenty-one of the cases were in females and all were under thirty-six years of age. There is still some question as to whether the loss of hair after any severe febrile affection is due to interference with the nutrition or to a toxin action directly on the hair papillæ, although the former view is more generally held. Most authorities agree that a pre-existing seborrhoea makes the loss of hair more certain.

H. H. Hazen reports having observed fifty patients who suffered from alopecia following influenza. Of these, three were men and forty-seven were women. The fact that the female seems to be more susceptible is perhaps due to the fact that women are more inclined to consult a physician than the men, because the latter feel that the affection is trivial and not worth troubling about. As the epidemic was more severe among the young, it is also natural that the alopecia patients were young. Unquestionably, the severity of the disease has much to do with the subsequent loss of hair. One-third of the patients had had severe pneumonia, and only five of the fifty had had fever of less than 102.5 degrees F. It is doubtful if seborrhoea (pre-existing) had any great bearing on the subsequent alopecia for the reason that twenty of the fifty patients stated that they had had practically no dandruff, and the scalps of twenty-two of the fifty were absolutely free from any local trouble. The average beginning of the alopecia was nine weeks. The shortest time elapsing from the onset of the influenza to the time was two weeks, and the longest three months. The amount of hair lost varied greatly. In one case there remained only one tuft of hair on the back of the scalp, and, as another extreme, not more than one-tenth of the hair was lost. As nearly as could be estimated, the average loss of hair was from one-third to one-half. As a rule, only the long hairs fell, and these were almost immediately replaced by short hairs, so it is possible that new hairs simply pushed out the old hairs that had been damaged. The greatest loss of hair was usually over the

anterior and parietal portions of the scalp. The alopecia was diffuse, not patchy, although in two cases there was a tendency towards patchiness. In one instance there was one completely bald area about one and a half inches in diameter. Only twelve of the patients complained of sensitiveness, either local or general, of the scalp.

Post-influenzal alopecia differs in no wise from any other postfebrile alopecia. In practically all cases the prognosis is excellent. Simple cleansing of the scalp and a stimulating tonic with ordinary hygiene of the scalp is all the treatment required.—*Boston Med. and Surg. Journ. and Jour. Amer. Med. Ass'n.*

HEREDITARY CORNS ON THE PALMS AND SOLES.—Kaposi was probably the first to report a case of circumscribed hereditary hyperkeratoses of the palms. This case, however, was not studied in detail; hence little is known about it. Audry describes in detail a case of hereditary corns on the palms and soles which occurred in a woman forty-one years of age. The lesions had been noticeable since the fifteenth year. The same lesions had existed in her grandfather, her mother, and three maternal aunts. Her three maternal uncles, however, and her own son were free from the disorder. On the palmar surfaces of the palms and fingers were hyperkeratoses of the size of a sago grain. They were disseminated in great numbers, and were embedded in the epidermis, through which they projected slightly. There were no evidences of inflammatory reaction, and the lesions had the usual hard, corneous center implanted in what appeared to be normal skin. Aside from a slight hyperidrosis, the patient's hands were normal. The corns on the feet were similar, but less elevated and less numerous than those on the palms, and were located on the plantar surfaces of the toes.—*Bull. Soc. Franc. de dermat. et de syph.*

PLANTAR AND PALMAR PUNCTATE KERATOSES.—Galloway and Adamson report two interesting cases of plantar and palmar punctate keratoses occurring in first cousins who were also man and wife. One of the patients was a frail woman thirty-five years of age who had suffered from the presence of the punctate lesions on her hands and feet since her childhood. They were yellowish-brown, fattish nodules which varied in size from minute points to that of millet seeds. The nodules were papules which consisted of very horny epithelium and were never vesicular. In time the nodules tended to flatten, and finally became depressed below the surrounding surface. Many of the papules showed definite pitting at the summits or centers. The condition of the soles was the same as that of the palms. The patient suffered no pain from the papules, nor was she caused any inconvenience by them except that when the lesions became long they caught in her needlework. To overcome this she made a practice of trimming or digging out those lesions which annoyed her in this manner. The case of the husband was similar to that of the wife except that it was much less severe.

Nothing of interest was disclosed by a histologic examination. The treatment consisted in the local application of a salicylic acid ointment without much improvement. Adamson and Weber, in discussing the presentation of these cases before the Dermatological Section of the Royal Society of Medicine, were of the opinion that the cases were of the nature of nevi.—*Brit. Jour. Dermat. and Syph.*

SYMMETRICAL KERATODERMA.—Vilvandre, of Sequeira's clinic in London, describes a case of extensive keratoderma in a child five years of age. The



patient had suffered from no illness except measles, and no other member of the family, which included five other children, was affected. The father and mother were also healthy and free from any skin affection. There was no history obtainable of any hereditary factor. The skin of the affected areas was thickened, greyish-black in color, and there was some hypertrichosis. The hands, forearms and elbows, both feet, part of the legs, especially the knees, were involved. The lesions on the lower extremities, especially at the knees, tapered to a point on the tibia and the thighs in the form of lozenges. The plantar surfaces of both feet were symmetrically affected, and the lesions were of a dark, blackish-grey color, and deeply fissured, resembling the bark of a tree. The dorsal aspects of the feet were also involved, where the affection extended in a pointed manner to the lower part of the legs. The hands, both dorsal and palmar surfaces, were affected, and the indurated, thickened skin reached to the elbows on the anterior aspects, and to just above the wrists on the dorsal surfaces.

The case appears to fall into the group of symmetrical hyperkeratoses of which tylosis is the more common type. The case differs from common tylosis in the invasion of the knees and the dorsal surfaces of the adjacent parts of the limbs.—*Brit. Jour. Dermat. and Syph.*

## PATHOLOGY

Conducted by JNO. G. WURTZ, M. D.

EARLY LESIONS IN THE GALL BLADDER.—In order to stimulate greater interest and more detailed research in conditions of the bile passages which have been mistaken for normal, MacCarthy and Corkery (*Amer. Jour. Med. Sc.*, May, 1920, p. 646) classify 4,998 gall bladders. Four thousand eight hundred and twenty-eight showed unquestioned gross pathological lesions, 157 slight lesions and 17 apparently "normal," most of which revealed changes in the villi upon examination with the microscope. Early changes in the gall bladder consist of: congestion and edema of the villi; local or general slight degree of lymphocytic infiltration manifested only in a slight enlargement and cloudy appearance of the villi; and the presence of fibrosis.

THE EFFECT OF TOBACCO ON THE VASCULAR WALL.—Tsang G. Ni (*Jour. Lab. Clin. Med.*, May, 1920, p. 534) states that the inhalation of tobacco causes a contraction of the arteries. He recalls the work of others to show the increase of pulse rate, systolic pressure and increase of pulse pressure. The changes mentioned are brought about by the direct action of nicotine on the vessels themselves, by the stimulation of the adrenals and by action on the vasomotor center. The veins are affected as well as the arteries. That no great distress is caused by the use of tobacco is probably due to the fact that tobacco attacks the hemoglobin causing a diminution of the oxygen-carrying power of the blood, allowing the accumulation of organic acids, which, in turn, because of their slight concentration, cause a vascular dilatation.

ARTERIOSCLEROSIS IN WILD ANIMALS.—Herbert Fox (*Amer. Jour. Med. Sc.*, June, 1920, p. 821) reports the analysis of 5,464 autopsies on wild animals. Particular attention was paid to diseases of the vessels which cover productive endarteritis and degenerative arteritis or arteriosclerosis, all of which the author considers under the head of angitis. Among the

5,464 autopsies only 86 cases of angeitis were discovered, or about 1.5 per cent. Mammals presented 33 cases out of 1,806 of these autopsied; birds presented 53 cases out of 3,571 autopsied. After a discussion of the anatomy and physiology of wild animals and a consideration of the effects of captivity and artificial feeding of these animals, Fox closes with the observation that, "Animals most affected are those prepared by nature for severe or prolonged physical effort, such as in fight and flight."

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## UROLOGY

Conducted by LEON T. ASHCRAFT, M.D., F.A.C.S.

**TUMORS OF THE BLADDER.**—W. Jones (*Canadian Pract. and Rev.*, 99, 11, xlv, 177) suggests that as tumors of the bladder are usually found near the ureteral orifices, they may be due to something in the urine! According to his classification, these tumors may be of epithelial, connective tissue or dermoid origin, the first two of which may include both benign and malignant growths. The only symptom of a benign papilloma may be irregular hematuria. These single tumors are potentially malignant and often recur after operation. The papillomas that are malignant from the beginning are usually multiple and sessile; are furnished with short villi; are surrounded by thickened mucous membrane and grow rapidly. Malignant bladder tumors are commonly accompanied with increasing hematuria, spontaneous cystitis, pain and emaciation. In making the diagnosis, one should resort to cystoscopic examination followed by the use of the x-ray with thorium, and examination through the rectum or vagina. Jones thinks that benign villous tumors and recurrences should be treated by means of fulguration, but that the open operation should be employed for malignant and extensive growths.

**HYDRONEPHROSIS; ITS DIAGNOSIS AND TREATMENT.**—Sargent (*Wisconsin Med. Jour.*, 1918, xviii, 60) believes that on account of the absence of associated symptoms and of urinary and physical signs, one should suspect hydronephrosis in every case of unilateral pain, especially in a young woman. In order to arrive at a correct diagnosis, one must catheterize the ureters and study the divided urines, estimate the function of each kidney by means of the phenolsulphonaphthalein test, employ pyelography, and make a careful study of the outline of the renal pelvis with its major and minor calices. Among the earliest changes that can be found by pyelography are blunting or obliteration of the minor calices, widening of the base of the major calices and an increase in the size of the renal pelvis. If the function of the hydro-nephrotic kidney is completely lost, a neprectomy should be performed. If, however, a fair amount of function is left, the obstruction should be removed. This is possible only when the case is seen early.

**THE DIAGNOSIS OF URETERAL CALCULI.**—Eisendrath (*Chicago Med Rec.*, 1919, xli, 211) emphasizes the shadowgraph catheter as one of the most valuable aids in making a careful and painstaking diagnosis of the presence of ureteral calculi. Another very important help is furnished by stereographic roentgenograms. As ureteral colic occurs in other conditions of the urinary tract, and even in conditions not within it, this symptom cannot be considered as one of much significance in making the diagnosis.

**VARICOCELE.**—Finochiette (*Semana med.*, 1919, XXCI, 559) states that although varicocele has been thought to be due to rupture, he believes that a closer study would show that this is not the cause. The usual surgical

methods cure the majority of the cases. Complications, however, are to be expected when an operation is used that does not primarily act against reflux, or that destroys the spermatic artery without previous evidence of the existence of a sufficiency of collateral circulation. It may also occur when any ligature is placed on veins of the interior packet without previous dissection and separation of the spermatic artery. Any venous ligature placed near the testicle by which thrombosis may be produced is liable to cause the condition. The operation should not sacrifice dilated veins just because they are dilated, and without first verifying the facts regarding reflux.

**HOURL-GLASS BLADDER; REMARKS ON THE RESECTION OF THE BASE OF THE BLADDER FOR TRANSVERSE SEPTA.**—J. R. Caulk (*Annals of Surgery*, 1920, LXXI, 22) reports two cases of this condition, one in a male, and the other in a female. Cystoscopic examination showed the presence of bands running transversely across the base of the bladder, and fanning out on the bladder wall. The author was convinced that incising these bands would not effect a cure, because they involved the entire bladder wall. The operation that he performed consisted in resecting the band; and, in the first case, also a portion of redundant mucosa, which was so loose that it could be pulled down in such a way as to cover the urethral orifice, thus explaining the complete retention of urine that had existed just prior to the operation. The result in each case was excellent. The author claims that this operation is not a difficult one, and that it can be done from the outside; but one must exercise care in approaching the external vesical coat. The resulting hemorrhage may be readily controlled.

**THE PALLIATIVE TREATMENT OF URETHRAL STRICTURE.**—Stern (*New York Med. Jour.*, 1920, CXI, 4) states that the end results of palliative treatment in such cases are superior to the results of external urethrotomy. Inflammation of the strictured area and edema are responsible for the symptoms of difficulty in urination and gradual lessening in the volume of the stream of urine. After the subsidence of these symptoms, an effort should be made to soften the infiltrate to expedite its absorption. The treatment should not be begun too early. Too active measures often produce a relapse. In some cases, however, operation is required. In such cases, one should not temporize, as it is not only useless, but dangerous. In the non-operative cases one must distinguish between an anemic infiltrate and an infiltrate with inflammation. The author describes his method of palliative treatment as follows:

Patients with inflammatory stricture and occlusion of the urethra should be sent to the hospital at once. The bladder should be emptied. One should then give a hypodermic injection of morphine sulphate before undertaking any urethral manipulation. Two drams of one per cent. novocaine solution, containing three drops of adrenalin should be injected and allowed to remain in the urethra for ten minutes. Usually the patient can then void voluntarily; but if he cannot do so, a No. 16 blunt-end metal, or soft rubber catheter should be passed. Should this not be successful, the insertion of a ureteral catheter with a No. 3 prove-end may be tried. When this catheter does not enter, Stern uses a urethroscope of the Guerringer type. This instrument was devised by the author and used with much success. In a number of cases, the trouble was caused by slender bands. After these had been destroyed by means of fulguration, one could readily pass small sounds. In inflammatory strictures with partial retention, Stern has secured good results with a hypodermic injection of morphine sulphate, a hot hip bath and con-



tinued rest, the stricture being treated through an instillation syringe, with argyrol solution alternated with warm boric acid solution.

The author regards cases in which bleeding does not occur after the use of instruments and in which the urine is clear, as instances of anemic stricture. These strictures may be treated with gradual dilatation. While Stern does not claim that this method produces a permanent cure, he feels that by means of it the condition of the patient is gradually improved. No further treatment is usually required for a year; and in some cases, it seems that an actual cure has been obtained.

**A PLASTIC OPERATION FOR THE CURE OF URETHRAL STRICTURE.**—Stern (*Jour. Am. Med. Ass'n*, 1920, LXXIV, 85) says that as external urethrotomy will not produce permanent benefit, and is never resorted to with the hope of producing a cure, an operation that will secure such results should be substituted for it. The procedures devised by Russell, Marion and Cabot have some advantages over external urethrotomy. They are, however, difficult to perform, because they injure the corpus spongiosum, thus producing hemorrhages that obscure the view of the field of operation. The author suggests a method of overcoming this difficulty. The floor of the urethra at the bulbo-membranous junction is excised without inflicting injury upon either the overlying structures or any other portion of the canal. Before the operation, a ureteral catheter is introduced through the stricture with the help of an instrument devised by the author. The operation is followed by primary union, there being no escape of urine. As nearly all strictures are situated anterior to the superficial layer of the triangular ligament, this operation can easily reach them. Neither infiltrating abscesses nor extravasation of urine need be dreaded, because the portion of the urethra posterior to the triangular ligament is not disturbed.

**SOME PRACTICAL POINTS ON PROSTATIC SURGERY.**—Deaver (*Am. Jour. Med. Sci.*, 1920, CLIX, 1) refers to three points that he believes will reduce the mortality of prostatectomy. The first is the recognition of absolute contra-indications to this surgical procedure; the second, the recognition of relative contra-indications; and the third, preoperative treatment to remove the relative contra-indications and place the patient in the operable class. He cites subnormal function of the kidneys as furnishing an illustration of these three points. Impending uremia caused by chronic interstitial nephritis is an absolute contra-indication, because it cannot be removed. In mild chronic interstitial nephritis, however, the subnormal renal function may be due to the back pressure of obstruction. As this condition may be improved, the contra-indication to prostatectomy is only relative in such cases. The success of the surgeon is much more governed by his ability to recognize and remove relative contra-indications to operation than by his surgical skill. Throughout the United States the mortality rate following prostatectomy is twenty per cent., and sixty per cent. of these deaths are due to uremia, hemorrhage, shock and sepsis. The percentage caused by uremia and sepsis is practically equal to that caused by hemorrhage and shock. That is, half of the operative mortality is due to conditions that contra-indicated operation, and the other half to complications arising from the operative procedure itself. Therefore preliminary treatment of relative contra-indications, together with the prevention of hemorrhage and shock, by employing proper operative technique, would greatly reduce the mortality rate of prostatectomy.

**FACTORS OF SAFETY IN PROSTATIC SURGERY; INDICATIONS FOR THE OPERATION.**—M. Meltzer (*N. Y. Med. Jour.*, 1919, CX, 942) states that a number of careful examinations should be made before resorting to prostatic surgery, in order to determine whether the operation may be done with safety. If the patient is already manifesting evidences of uremia, drainage of the bladder, together with the use of fluids and urinary antiseptics, may soon improve their general condition and the function of the kidney. The period when a favorable condition for enucleation of the prostate has been reached must be determined by the following: (1) the appearance of the tongue; (2) the blood chemistry, with especial reference to the retention of creatinine, urea nitrogen and nonprotein nitrogen; (3) the renal function; (4) the general condition. The tongue shows the inability to excrete through the kidneys toxins due to bladder obstruction in prostatitis. It is dry, rough and cracked, and is either a dirty brown or a bright red in color, with an enamel-like lustre. When an investigation of the chemistry of the blood shows high figures for the constituents referred to, only urinary drainage and expectant treatment should be resorted to. The renal function is estimated by means of the phenolsulphonephthalein test. Radical surgical treatment is contra-indicated by a failing myocardium, a decompensated valvular lesion, marked edema, generalized anasarca, cirrhosis of the liver and excessively high or low blood pressure.

**ESSENTIALS OF SUCCESS IN PROSTATIC SURGERY.**—Cunningham (*N. Y. Med. Jour.*, 1920, CXI, 138) considers that in the preparation of the patient for prostatic surgery, the use of the cystoscope is of great value in obtaining information concerning the existence or nonexistence of malignant growths. Free drainage of the bladder, either through the urethra or otherwise, should also be secured; various functional tests should be employed; and the patient should be observed for a sufficient length of time to reach a correct judgment as to whether the case is an operable one or not.

The author divides the operative cases into two groups: those in whom radical surgery is advisable, and those in whom more conservative measures must be employed. Among the conservative methods, he mentions the Bottini and the Chetwood operation, and the establishment of a permanent suprapubic sinus. He considers the punch operation indicated in the bar type of case, with contraction of the neck of the bladder.

In performing a radical operation, Cunningham prefers gas-oxygen anesthesia. He employs the suprapubic route only in the case of those whose general condition is good. In patients whose general condition is poorer, or when the gland is of the small fibrous variety, he does either the perineal dissecting operation or the median perineal enucleation procedure, the latter being the quicker and the more suitable for patients in poor condition. Only in rare instances does the author advocate the removal of malignant prostates.

He lays special stress on the importance of postoperative care. He employs the Pilcher bag to prevent hemorrhage after the suprapubic operation. Perineal bleeding is controlled by packing. When the punch operation has been performed, a De Pezzer catheter drawn down tight to the vesical sphincter will meet the requirements. Wound infection is to be anticipated, if at all, only in those on whom a suprapubic prostatectomy has been done. To prevent its occurrence, trauma at the time of operation should be avoided, complete hemostasis should be employed, and the wound properly closed. If infection should occur, free drainage must be supplied.

# THE HAHNEMANNIAN MONTHLY.

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HAHNEMANN, CHEMIST, PHYSICIAN, PHILOSOPHER.

BY

AUG. KORNDORFER, M.D., PHILADELPHIA.

(Read before the Kings County, N. Y., Homœopathic Medical Society.)

WHEN reviewing the life and studying the work of one who has been instrumental in developing world-wide reform in any department of science or art, we may profitably inquire into the individual characteristics upon which such special power appears to depend; the scope and degree of acquired knowledge, and the special fitness for the field of service upon which such a one has directed his energies.

Approaching the subject of our present inquiry from this viewpoint we learn, that in his boyhood he was an apt and earnest pupil, winning the commendation and friendship of his teachers; as a student he was industrious and ambitious to acquire knowledge and secure experience; as an investigator he was cautious, critical, discerning in observation and discriminating in judgment. His power of analysis was highly developed and his inductive reasoning evidenced the master mind.

Trained as a physician under the leading teachers of his day, experience soon taught him the inadequacy of the prevailing medical views and methods: a fact that for a time led him to direct his energies into the field of chemistry and physics. As a science, chemistry still was in its infancy. The wildest theories of matter and force were frequently advanced by men of repute, and the absurd fancies of the alchemists still



found adherents. But few elementary bodies were known and the most vague and unsatisfactory theories still hampered experiment. Despite all this Hahnemann, by persistent study and independent research, coupled with ceaseless effort, acquired great technical skill as a chemist, and a profound knowledge of the scientific needs of his profession, as a physician.

Aided by his remarkable linguistic acquirements he was able to study, in the originals, the works of the most advanced chemists and physicians of his day; an advantage of great worth to the true student. During his entire professional career we find that his thoughts and efforts were constantly directed along the lines of critical and painstaking search for and analysis of facts, coupled with an exhaustive study of the legitimate deductions from such facts, insofar as they applied to chemistry and medicine.

In 1784 Hahnemann translated Demachy's "Art of Manufacturing Chemical Products." This valuable work had wide acceptance and an extended circulation, being especially prized by reason of the correction of many errors found in the original, as well as on account of the many important additions from Hahnemann's pen. Among other features worthy of note in this connection must be mentioned: His improvement in apparatus for distillation; his improved areometer; his improved method of draught for laboratory furnaces; his special retorts, hearths and grates; his tests for arsenic and for certain acids; his preparation of soluble mercury; his wine test, or better termed test for metals; these alone would be enough to mark his work as that of an expert of no mean ability, yet they form but a small portion of most praiseworthy advanced work which must be placed to his credit.

Hahnemann's "Apothekerlexikon," a work of over 1200 pages, was published in parts, the first in 1793, the last in 1799. It was received with much favor and was for many years the standard reference book for German apothecaries. In this work he gives many important suggestions and directions in regard to the preparation of certain medicinal extracts. His preparation of tinctures from fresh plants, and many other points of improved method and technique mark this work as far in advance of his day. The many suggested improvements found in his "lexicon" marks *it* as of superior worth, and marks *him* as gifted with a master mind and possessed of an independent and searching spirit of inquiry, fitting him to be

a leader and guide in his chosen field of research—medicine. His chemical knowledge and technical skill were freely recognized by some of the leading chemists of his day. One reviewer, in 1799, writes of his lexicon as “a work by a man who has made for himself a name in Germany, both as a chemist and as a practitioner, deserving especial commendation;” and Trommsdorff, Professor in the University of Erfurt, speaks of it as “an excellent work which every apothecary ought to possess. Brevity, lucidity, decision and yet withal completeness seem, so far as we can judge, to distinguish this work from all others of a similar character.” Professor Crell, in his “Annals” says: “Dr. Hahnemann has rendered many services to science, both by his own writings on chemistry and by his excellent translations of important foreign works. His services have already been recognized but they deserve to be still more so.” Many more commendatory criticisms might be quoted but for our purpose these will suffice.

We next find the subject of our review advancing along the lines of the practical application of his knowledge to the use of drugs in the curative treatment of disease. With such highly developed preparation for the special study of the character, quality and therapeutic action of drugs, Hahnemann entered upon the work of founding the practice of the Healing Art upon a scientific basis, with all the ardor and enthusiasm of which such a spirit is capable.

It was while engaged in the translation of Cullen's *Materia Medica*, in 1790, that Hahnemann was led to the discovery which eventuated in the development of homœopathy: first clearly announced in his celebrated “Essay Upon a New Principle of Ascertaining the Curative Action of Drugs,” published in 1796.

I will not tax you with a review of the irrational speculative notions in vogue during the latter years of the eighteenth century and for long years thereafter; let it suffice to say that with the essay of 1796 a new era was begun; but here like with every great advance in science, opposition was met. “A savage partisan spirit” possessed the profession and even spread to the laity. Dogmatism and intolerance with their twin companions, ignorance and persecution, ruled in the profession, while science as applied to medicine was stifled nigh unto death.

Just here permit me to digress a moment in noting the

fact that Hahnemann had for years prior to the publication of the essay referred to, shown a marked advance along the lines of hygiene and sanitation. In fact, some of his articles that appeared in his "Friend of Health," as well as his published views regarding the nature and care of infectious diseases were nearly a century in advance of his time. His article on "Making the Body Hardy;" his thoughts upon the subject of "Vocational Training for the Correction of Physical Defects;" his views upon "Dietetics," all manifest a decidedly progressive and advanced line of thought, and bear favorable comparison with present day teaching.

His essay upon "The Mode of Propagation of the Asiatic Cholera," clearly proves his deep insight into the underlying causes of disease. Therein he speaks of the contagious matter as being composed of "exceedingly minute, invisible, living creatures inimical to human life;" and again he refers to "the invisible cloud that hovers around the sailors (on an infected ship) but who have remained free from the disease," as being "composed of probably millions of these *miasmatic* animated beings."

This latter sentence enables us to interpret his meaning of the term "miasm," as involving a material as well as a dynamic element, though it is true that he looked upon the dynamic element as being by far the more important factor.

Again, Hahnemann's wonderful grasp of the conditions involved in mental diseases; his reforms in the treatment of the insane, substituting mild and gentle care for the, till then, cruel, even barbarous, methods in common use, mark his work in this field as a notable and most salutary reform. It is worthy of mention that Hahnemann instituted this reform contemporaneous with or somewhat antedating Pinel, who introduced a similar method in the Bicetre, in 1792. It was in that same year that Hahnemann treated and cured the Chancellery Secretary Klockenbring, of Hanover, in the asylum at Georgenthal. In reference to his treatment of the insane Hahnemann wrote: "I never allow an insane person to be punished either by blows or any other kind of corporal infliction, because there can be no punishment where there is no sense of responsibility, and further, because such patients cannot be improved but must be rendered worse by such harsh treatment." We find that even in his early practice Hahnemann manifested a degree of critical discernment and ripe



judgment in chemical, physical and psychic subjects far in advance of the profession at large. He was progressive but prudent, patient but strenuous and indefatigable in all his work. Individualization was the keynote to his investigations; comprehensive generalization based upon fundamental similarities was a result. Thus he made exhaustive provings of each individual drug in order to learn its specific power to alter the functional activities of the human body in health; but, when he studied the endemic and epidemic forms of disease he took the composite picture of many cases and sought a remedy that covered the totality. Having confirmed, through years of careful application of the proven remedies the general applicability of the law of similars, he nevertheless still was unsatisfied with his results in chronic forms of disease. This led him to devote years of study and research to the discovery of the cause of his less favorable results in such cases.

Rejecting all crude materialistic factors he sought long but successfully for a solution of the underlying cause.

Guided by a close study of the symptomatology of chronic forms of disease he ultimately arrived at a picture that portrayed the various forms as having certain subjective and objective manifestations in common; signs and symptoms, heretofore unrelated to any definite physical cause and many of them even then still unexplainable by any known facts in physiology; but the symptoms were so many facts, and Hahnemann's deep insight into the workings of nature led him to a practical solution as to the value of these facts, nearly a century before physiology could offer an explanation.

While making a careful study of these symptoms some years ago I was impressed with the marked similarity between them and the symptoms attributed to hypothyroidia. A further analysis showed that a majority of the symptoms which Hahnemann referred to *Psora* were attributable to a lack of, or perversion in, the secretions of the endocrinous glands. Hypothyroidia is characteristically represented by a large number of such recorded symptoms, and when associated with impaired secretion of other glands we find that the combination presents a complete counterpart of Hahnemann's *psora*.

Further study and extended analysis led to the conclusion that such faulty internal secretions in quantity or quality were responsible for the various forms of chronic disease and indi-

cated the true physiologic basis for Hahnemann's theory. His symptomatic picture tallies perfectly with conditions that we now know to be dependent upon such faulty secretions. This fact is further emphasized by *the known importance of the internal secretions as factors in a protective system against infection from without, as well as from excess of toxic wastes within.*

Knowing the important role sustained by the endocrine glands in the functional activities of our bodies and recognizing the relation of their secretions to all vital reactions, it is but a step further to trace the remarkable relation between drug action and the internal secretions. Not only has it been clinically established that the administration of these secretions in diseased states has a homostimulative and regulating action, correcting or restoring the functions where depressed or faulty, but we now know that *drugs* have a positive power both to excite action and to correct faulty functioning of the endocrine glands, thus pointing the way to further comparison and analysis. Our provings afford valuable material for such further investigation.

With adequate laboratory facilities coupled with skilled laboratory workers, workers gifted with creative genius and imbued with an intense love for homœopathy and truth, we may confidently anticipate wonderful revelations as to the action of our remedies upon all centers of physiologic activity in these bodies of ours, both in health and in disease.

It has been demonstrated that the nutritive functions are governed or controlled specifically by the stimulative action of the internal secretions. The thyroid, for instance, is responsible for the establishment and maintenance of many of the metabolic activities: it favors oxidation, controls growth, both of mind and body, and is closely related to all the other endocrine glands; it is one of the most important of the detoxicating agencies of the body and is also intimately concerned in the immunity-producing mechanism. Through its action upon the adrenals it as well as the adrenal secretion tends toward increasing lime assimilation and aids materially in bone development, thereby also hastening union of fractures, and in a word, these secretions augment the nutritive functions generally.

In cases of protracted hyperthyroidia we note emaciation, hunger, thirst, vomiting, diarrhœa, polyuria, profuse sweating,

tachycardia, neuralgias, rheumatism, as well as many other mental nervous and general physical symptoms. Of course, it remains for us to relate each such symptom as found in our provings to its causative factor, that we may interpret its meaning and rate its importance in any given complex of symptoms. The same thought applies to each and all the internal secretions, for diminution as well as perversion of either must be followed by more or less characteristic effects.

The oxidation function of the adrenals has been well attested, and the fact that they maintain the toxicity of the involuntary muscles and control the cardio-vascular tone, are points of much interest, marking not only the causative factor in diseased manifestations but pointing to the remedial agents as indicated in our provings. Again, it is both interesting and instructive to note that the adrenals are stimulated by emotional strain (pain, fear, worry, rage, etc.), thus confirming Hahnemann's estimate of the relation and importance of the mental symptoms in physical diseased states. We must also note that abnormal endocrine function elsewhere in the body, as well as any form of toxemia, tends to stimulate the adrenal secretion. Such stimulation though at first palliative, soon tends toward exhaustion of the function with consequent general aggravation of the previous symptoms, and speedily results in the well-known asthenia and vascular atonicity which, if prolonged, soon induces malnutrition and emaciation.

It is well to remember that asthenia, hypotension and malnutrition are the three characteristics of faulty adrenal secretion observable in long standing chronic infections, tuberculosis being a typical example. It may, indeed, be accepted as a confirmed fact that the adrenal secretion is more or less seriously involved in all cases of long standing chronic infection.

In conjunction with the foregoing we must note that the pituitary body is the general governing center of the spinal system, which includes the gray substance at the base of the brain, the pons, bulb and the spinal cord, being in fact the governing center of all the vegetative functions. The pituitary hormone serves as a general muscular tonic and vascular stimulant. Lacking its normal action we have apathy, lethargy, hemianopsia, infantilism, mental dulness, adiposity, Frohlich's syndrome, neuralgic pains, cardiac asthenia, etc., and here again our provings lend confirmation to the correctness of the physiologic findings.



Thus we see coming true Hering's oft repeated assertion: "Our materia medica will make possible a new physiology and on that, in turn, we may base a new and true pathology."

Every proving made by Hahnemann, being the record of the pure effects of a single drug presents a picture, from and through which we may trace effects to their primary cause, thus finally enabling us to discern the relation between known functional action and the symptomatic expression of effects from any extrinsic interfering factor, such as disease or a drug employed in proving. As before stated a large number of the symptoms recorded by Hahnemann as evidence of psora, are identical with those which we now know to be related to hypothyroidia, and owing to the physiologic relation between the thyroid and the adrenals, and, as both are under the controlling influence of the pituitary, we can readily understand Hahnemann's psora as hypothyroidia more or less complicated, with a resultant hypoadrenia, both of which may be associated with faulty function of the pituitary body.

Even the less common and unusual symptoms recorded in the provings confirm this. It all proves that Hahnemann discovered and described the condition a century ago under the term psora which physiology is just now able to explain, through the action of the internal secretions.

Hahnemann did not reach his conclusions after any haphazard manner. It was only after eleven years of painstaking investigation and critical analysis of facts, that he felt warranted in publishing his results. In 1828, Hahnemann wrote, "This most important problem engaged my attention since 1816-1817, by day and by night; and behold the Giver of every Good permitted me gradually, through unceasing meditation, indefatigable research, trustworthy observation and the most accurate experiments to solve the sublime problem for the benefit of mankind." And then he states that he did not make his views known prior to 1827, because, "it is unwise and even injurious to announce such things while still immature." Only after eleven years of research did he reveal to two of his most faithful followers, Stapf and Gross, the results of his labors, "that in the event of his death the work might still go on."

Today we realize that the explanation of Hahnemann's symptomatic picture of psora is found in a disturbance of the functional activities of the endocrinous system. The test organ

with its keen and sensitive powers, the pituitary body with its prompt conveyance of the nerve impulse, the later morbid effects upon the thyro-parathyroid and the adrenal secretions, all are factors in the disease changes. To Hahnemann we, indeed, owe lasting honors for his wonderful insight into the underlying evidence which pointed to the cause upon which chronic as well as acute infectious disease depends; and for the immeasurable benefit humanity has derived through his practical application of the results of his investigations. He thus early utilized a conception of disease action which science with laggard step required a century to reach and explain.

That he did not solve the question as to the identity of the then hidden cause is true, nevertheless it is equally true that he did perceive and utilize the knowledge of the relation between the symptoms and conditions which he correlated and interpreted as fundamentally underlying the causative factor, and the drug symptoms observed in his provings, all of which he made useful in the work of healing the sick and in advancing medicine on the road of scientific accuracy and success. He revealed and made practical use of the facts; it remained for the present generation to discover and define the underlying physiologic cause. Hahnemann contended that chronic diseases commonly developed through the suppression of the external manifestations, *i. e.*, skin lesions; such suppression resulting in a perversion in the action of the vital dynamis which in course, developed more serious, more lasting and more intractable forms of disease.

I dare not consume your time in a detailed review of the many interesting references quoted by Hahnemann in the first volume of the *Chronic Diseases*, and through which he traced the condition which he termed Psora from its earliest manifestations in the form of leprosy, down through the many changes in its mode of expression to "the various forms of skin diseases so exhaustively differentiated and named by William." In addition, Hahnemann enumerated many and varied forms of diseased states confirmatory of his theory of psora, and it is but justice to admit that he brought to light most excellent warrant for his conclusions. True the modern language of science would clothe his views in other words, but the facts must ever remain the same.

That the accumulation of toxic waste products may indeed be a cause of functional changes we may readily admit,

but how could we have such increase of toxic waste products except the normal physiologic force had previously been perverted? In other words changed tissue presupposes changed dynamis. Changed functional action must, if sufficiently marked, give rise to a train of morbid symptoms typical of disease, but we must note the fact that the individuality of the patient gives rise to those more or less unusual symptoms which are striking or peculiar and differentiating in the individual case—characteristics that point unmistakably to the individual, *i. e.*, specific remedy.

Viewed in the light of the action of the internal secretions, the active agents in the vital processes, and with a knowledge of the effects of any perversion of these secretions upon normal functional activities, we find much to confirm Hahnemann's teachings in regard to chronic diseases.

Sajous, in his epoch marking work on the "Internal Secretions" has shown the importance of the adrenal system, *i. e.*, the pituitary body, adrenals and thyroid, as the immunizing mechanism of the body. He has logically demonstrated that its action enhances the functional activities against disease, causing an increase of auto-antitoxin in the blood. It acts as a deterrent and corrective in accordance with special need. This auto-antitoxin is composed of the internal secretion of the adrenals (adrenoxidase, Ehrlich's amboceptor); of the pancreas (trypsin, Ehrlich's complement); of the spleen and leucocytes (nucleo-proteid); and of the thyroid and parathyroids (thyroidase, Wright's Opsonins).

Suppression of any skin eruption may, through the accumulation of toxic waste products in the blood so overwhelm the test-organ as to seriously impair the action of the pituitary body, and as it is the governing center of the vegetative functions of the body and of each organ individually, such impairment may reduce or even render nugatory the action of the entire adrenal system thus permitting a practically unrestrained accumulation of toxic waste products in the blood and eventually inducing the development of more or less acute or if prolonged chronic forms of disease.

This train of effects may be overcome through the action of remedies that stimulate the functional activity of the test organ, which, in turn, will enable the pituitary body to arouse the entire protective apparatus, thus inducing an increase of auto-antitoxins in the blood. The action of the homœopathi-



cally indicated remedy induces what might be termed by reason of similarity of action homostimulation of the affected gland or glands. Such stimulation, if kept within physiologic limits, must prove curative. As the disease causing substances, toxins, endotoxins, toxic wastes, etc., produce their effects through a morbid action upon the centers affected, which centers are *also readily influenced by other remedies*, the condition may thus be met directly at the seat of diseased force and antagonized before it can seriously impair health or endanger life.

Every proving made in accordance with Hahnemann's method reveals unmistakable evidence of definite action upon one or more of the endocrine centers. Even the less frequently observed symptoms, distinctly related to such faulty functioning, such as hemianopsia, which is often observed in disease affecting the pituitary body, is found in a number of our antipsorics, as well as among the prominent polychrests often useful as intercurrents in the treatment of chronic forms of disease. Thus we may note: arsenicum, aurum, bovista, calcarea, camphor, cocculus, digitalis, gelsemium, glonoin, lithium, lycopodium, muriatic acid, natrum muriaticum, sepia, stramonium, zincum; each has produced this symptom and each has proved curative in the same.

Pointing as this condition does to a possible involvement of the pituitary body, we may seek further for confirmation. If we find indications of adiposity, asexualism and impaired development, *i. e.*, persistence of infantile characteristics; or if evidence of renal disease, weakened heart's action, tachycardia, dyspnoea, malnutrition, asthenia, intellectual obtuseness, poor memory, hypothermia, sense of fatigue, muscular pains, apathy and sleepiness are manifest, we have confirmatory evidence pointing to faulty action of the pituitary. In such cases we will find in the provings of our antipsorics the true counterpart of the individual case, always bearing in mind the fact that the real similimum must cover the individual characteristics of the patient as well as the general symptoms of the disease.

If we review the remedies known to be useful in conditions consequent upon strong emotional arousalment as from anger, grief, fright, worry, etc., we find the same fact holds true as pointing to adrenal insufficiency.

Again, when we consider the many symptoms and conditions indicative of *faulty thyroid action*, such as mental obtuse-

ness, melancholia, occipital pains, falling out of the hair, or hair turning gray prematurely, hallucinations of sight or hearing, swelling of the naso-pharyngeal mucous membrane, tonsils liable to acute inflammation, dyspnoea, palpitation, weak pulse, impotence, prostatic hypertrophy, amenorrhoea, neuralgias, great weakness, trembling, convulsions, imperfect bony development, rachitis, as well as such skin affections as pruritus, prurigo, ichthyosis, pityriasis rubra, scleroderma, psoriasis, etc., and compare such remedies as arsenicum, aurum, baryta, causticum, cuprum, fluoric acid, graphites, the kali salts, lachesis, the lime salts, lycopodium, mercury and its salts, especially the iodides, petroleum, phosphorus, silicea, and many others, we may clearly perceive the relation between the symptoms of our antipsorics and the affections involving the thyroid or rather the thyro-parathyroid secretions. Thus we might spend hours reviewing our provings in the light of the newer physiology, noting and comparing the symptom complexes in relation to the physiology of the internal secretions, gleaned from each such study some new confirmation of the facts just stated.

The important feature upon which stress should be laid is the fact that our symptomatology in its richness enables us to select *the exact similimum* to the given case, thus making possible the administration of the true homostimulant. Physiology makes possible the solving of the *why*; our materia medica makes plain the *way*, but the completed solution rests with the coming generation of homœopathic physicians.

Hahnemann's method necessitated strict individualization. The part affected, the character of the affection and the name of the disease are not comprehensive enough for the selection of the correct remedial agent. We must have the "*totality of the symptoms*," the real characteristics of the case as portrayed in the mental state and in the sensations, conditions or pains, with location, direction, time and other modalities and concomitants to form a true and complete picture of the individual case; all of which must find its counterpart in the indicated remedy.

I need not speak of the effects of the potentization of our remedies, or of the minimum dose, as science has already vindicated Hahnemann in both particulars.

In all his work Hahnemann manifested the critical and searching spirit of the true philosopher. As an investigator

in all branches of scientific inquiry involved in the development of medicine he gave unmistakable evidence of clear insight, astute powers of reasoning and of accurate and discriminating judgment. No airy schemes or idle speculations led him from his search for fundamental principles upon which curative treatment must be based. He loved wisdom and sought knowledge and exact truth rather than applause and commendation. He accepted naught save that which could endure the test of crucial analysis and actual bedside experience. Facts were his guides and the legitimate deductions from such facts his aim. Nothing less could satisfy the demands of his rigorous and exacting conscience.

However, like every production of genius Hahnemann's discoveries elicited censorious criticism and vindictive opposition. Men of talent whose studies had narrowed their minds into restricted channels were incapable of grasping his thoughts, following his reasoning or understanding his conclusions, hence many of his contemporaries became his bitter opponents. Nevertheless, as truth will ever triumph, many practitioners became earnest inquirers, ardent admirers, zealous students and conscientious adherents of the new doctrines; and the principles and practice of homœopathy triumphed. The rays of knowledge which illumined his mind enlightened all who came under the influence of his masterful genius and irrefutable logic.

As a physician, he was learned, conscientious, progressive and on occasion aggressive. Deeply conscious of his duty and profoundly learned in his art, no labor was too strenuous, no sacrifice too great, no service too exacting for his devotion and zeal. As a servant of the Most High he gave himself without stint to the cause he loved and served. "When," said Hahnemann, "we have to do with an art whose end is the saving of human life, any neglect to make ourselves thoroughly masters of it becomes a crime."

His unflagging industry was simply marvelous; and as student, physician, investigator, writer he stood without a peer. He was the author of many valuable medical works as well as chemical treatises, and translated more than a score of works from English, French, Italian and Latin, among which we would especially mention: Cullen's *Materia Medica*, 2 vols., translated in 1790. *Monro's Materia Medica*, 2 vols., in 1791, and a second edition in 1794. *Albrecht v. Haller's Materia*



Medica in 1806, all of which were standard works of repute. But the information gleaned from these and kindred works proved too conjectural to satisfy his cravings for knowledge, therefore, he instituted the method of proving drugs upon which he founded his *Materia Medica Pura* and later the added remedies incorporated in his *Chronic Diseases*. Hahnemann was the first who thus instituted and *systematically conducted* the proving of drugs upon the healthy human body, declaring it to be the only sure guide to the knowledge of drug action for therapeutic use in disease.

He personally proved more than eighty remedies, the records of which we find in his *Materia Medica Pura* and his *Chronic Diseases* just referred to.

Hahnemann's energy and enthusiasm surely must put to the blush many of our younger men of today.

In the field of medicine he gathered and garnered the wisdom of the ages. His breadth of learning and his clear insight into the action of nature's laws, surely entitle him to rank as an honored representative of philosophy in the field of medicine.

His research brought truth to light, established order under law, developed method and system in both investigation and practice and finally assured the progress and development of his chosen profession along logical and scientifically correct lines; setting deep the foundations upon which might rest the true science of medicine.

Today we have the unspeakable pleasure of seeing that truth for which he suffered so much and so long, gradually pervading the whole structure of the temple of medicine which the twentieth century is building. To Hahnemann we owe it all.

May unfading honor and lasting glory crown his work, immortality be his reward, homœopathy the enduring monument to his fame.

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VIRULENCE OF DIPHTHERIA BACILLI FROM DIPHTHERIA PATIENTS AND FROM CARRIERS.—Wadsworth (*Jour. A. M. A.*, June 12, 1920, p. 633) gives the results of 548 tests to determine the virulence of *B. diphtheriae* in patients, contact and noncontact carriers. Results showed that 90% of the strains of *B. diphtheriae* from cases of clinical diphtheria, from the day of onset to and including one year after onset, were virulent for guinea-pigs. 80% of strains from healthy contact carriers during epidemics were virulent, while only 10% of strains from noncontact carriers showed this trait.

## HOMŒOPATHY: THE ONLY SCIENTIFIC AND ACTUALLY CURATIVE SYSTEM OF MEDICINE.

BY

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THE obsequies of homœopathy have been published so often in the medical journals of the old school, that it seems to be time to refute them and prove that homœopathy is very much alive and will live to see the day in the no distant future when it will be the only legal system in the practice of medicine. Truth may be long suppressed, but can never perish.

*There can be but one right way, all others must be more or less wrong. Only one straight line can be drawn between two given points.*

The truth of anything lies in the practical application of it, with the following real good and lasting results and homœopathy will stand this test pre-eminently. Tests at the bedside of patients will give convincing proof of this.

That homœopathy did not become at once and is not even now the only recognized legal practice of medicine is due:

1st. To the natural perversity of human nature, which is inclined to believe in follies much quicker than in actual truths. People in general require training in each direction ere they can see the truth in that line. They want to be fooled, as Barnum used to say, and it is the truth. Antitoxine for diphtheria, anti-typhoid serum for typhoid fever, a special serum for each disease according to its name; this seems so plausible, so rational that it takes like wild fire. And yet, no greater folly could ever be imagined. The same suit of clothing in size and shape for all persons, young and old, lean or stout, with the name of Jones, the same for all the Millers, the same for all the Smiths; treating a phantom disease which has no existence by itself, and is at first simply a dynamic derangement of the organism, widely different in each person and letting the patient linger or die.

And to give medicine for the prevention of disease is as ridiculous as the building of a bridge for a river that has never been seen, nothing known of its width, depth, force of current, and condition of bottom and shores, which may never have to be crossed, never even seen. That highly educated

people and even doctors in high government office believe in this nonsense, simply proves: That education is no bar to error or folly. Strict honesty, good common sense and sound judgment, all this with great kindness of heart, like the lamented Abraham Lincoln, tower high above education. Sanitation is the only preventive of disease; this alone prevented the return of yellow fever in Havana, Cuba, in New Orleans and Memphis.

2d. The great unheard-of novelty of this doctrine. It was too much for the learned doctors and professors to comprehend. That a remedy which had caused the symptoms of a disease when taken in material doses by a person in normal health, could cure that same disease presenting those symptoms when of natural origin, if the same remedy were given in very minute, infinitesimal doses, that required the giant mind of Hahnemann to evolve and grasp.

3rd. The very small, infinitesimal doses of the remedy, recommended by Hahnemann, as compared with the very large, complex and powerful doses of that time, made homœopathy seem foolish and ridiculous. Disease was then and is today, considered a powerful monster and to require massive doses to combat.

Yet we all know that the air we inhale is more necessary to sustain life in us than food. We could not live many minutes without it. And yet it is colorless, tasteless, odorless, intangible and well nigh imponderable. This proves, at least, that quality is of vastly more importance than quantity.

Roses and lilacs have caused hay fever and asthma in persons passing even at some distance.

A growth of poison ivy has caused vesicles in clusters and erysipelas in persons passing at a long distance. The poison of the plant carried to them by the breeze blowing over the growth toward them, cannot be detected in the air in any other way. Both the latter show the power of infinitesimals in nature, as also the wonderful effect of sunlight on everything on this earth, 93,000,000 miles from its source.

4th. The difficulty of the application of homœopathy in practice. The old school doctors who could descend so far from their lofty theories as to try homœopathy, gave the remedies as had been and still is their custom, for the arbitrary name of the disease, a phantom, all cases of disease of the same name were the same and identical to them, all were given the



same remedy and in material doses as well. The identity and peculiarity of the patient were entirely ignored, hence he lingered or died and homœopathy was a failure.

To get the patient's symptoms, then find the remedy in the homœopathic materia medica, presenting a similar group of symptoms, then give that remedy in a very small minute dose to the sufferer, that was not rational and withal too much trouble. Besides the homœopathic materia medica was filled with imaginary symptoms, which they had never seen produced or cured by it. That they could not see any such results, such symptoms, because they always jumbled a large number of remedies and large amounts of each drug in one prescription, this they failed to see.

Not many years ago I had four cases of scarlet fever in quick succession. Case 1. The surface of the skin smooth, scarlet red and burning hot to the touch. Throbbing headache, dilated pupils, throat sore and red on inner right side and tender to touch externally on that side; very irritable. Temperature, 104 degrees, worse swallowing liquids. Belladonna cured. Case 2. The discoloration of the skin was bluish, surface smooth, body not hot to touch. Temperature, 103½ degrees. Headache. Throat sore to touch on left side externally; worse swallowing saliva or empty swallowing; sensation of a lump in the throat, which goes down on swallowing but returns at once. Throat purplish internally, constricted, unable to swallow even a drop of water. A few minutes after falling asleep he awakens breathless; has to make special effort in order to breathe again; can not bear anything tight about the neck. Lachesis cured.

Case 3. Surface of the body was a bluish discoloration, the bluish parts are raised above the other parts of the skin, due to the swelling of the cellular tissue and lymphatics. Tongue coated light brown with a red triangular tip, the apex of the triangle pointing backward; the more he swallows the easier it becomes; burning in the throat; great restlessness; must move to get relief from the pains. Rhus tox. cured.

Case 4. A boy, aet. 10 years, presented all the symptoms of dysentery. Stools small, of mucus and blood with great tenesmus and straining continuing long after the evacuation, severe pain in abdomen. Merc. cor. cured this in three days, when all the symptoms of the smooth scarlet red variety of scarlet fever appeared, which was cured by belladonna.

These cases were cured in from five to eight days so perfectly that the parents would not believe they had been ill with scarlet fever; they had not been sick enough for that; had lost apparently no weight or strength, till desquamation set in, the skin peeling off in long strips.

The remedies were given in the higher potencies. No other remedy or combination of remedies could have cured them in the same manner. Large and strong doses of the same remedies would have endangered the lives of these patients.

But nothing convinces more or better than actual personal experience, and I know of no substance more suitable for this purpose than the table salt, sodium chloride, or natrum muriaticum. It has been in daily use all over the world since time immemorial, as an addition to the food, never produces any ill effects unless too much had been added to the food, when it might cause great thirst. It may, therefore, be said that in the crude state it is inert, has no medicinal virtue or effect, and for this reason as also for the ease wherewith it can be prepared as a homœopathic remedy by anyone, thus preventing any error or trickery, to be eminently suitable for this test. Hahnemann was the first one to introduce it as a remedy, proving, testing it on himself while in good health and showing its great and wonderful power to heal the sick. A number of Austrian physicians, who could not believe what Hahnemann had published regarding the effect of common table salt on the human organism, in the 30th potency, on healthy persons and to cure the sick when these symptoms presented themselves in them, formed themselves into a proving society, tested salt on themselves in the 30th potency and were convinced. It had acted better even in the 30th potency than in the lower.

To prepare it for medicinal use: One-half ounce of ordinary table salt is dissolved in an ounce and a half of boiling distilled water, filtered and allowed to crystallize by evaporating it at a temperature of 122 F. to free it from its associate salts. The crystals are allowed to dry on blotting paper. One part by weight of the dry crystals are dissolved in nine parts by weight of distilled water, enough to fill the bottle about one-half full, cork the bottle firmly, take it in the right hand and give two or more strong blows against the left hand or some other yielding substance, so as not to injure the hand or break the bottle.

Ten minims (drops) of this solution are added to ninety minims (drops) of distilled water given two or more blows as

directed above for the first solution; that is succussed twice or more times and this gives the first potency. One minim of the first potency added to 99 minims of distilled water (or alcohol if the potency is to be preserved for future use) enough to fill the potentizing bottle one-half full then succussed as before and this gives the 2d potency. This may be continued till any desired potency is obtained and it will prove active and a wonderful remedy to heal the sick. Substances which are inert in the crude state, like salt, charcoal, silicia, lycopodium, have been found most beneficial, most curative in the highest potencies.

Any potency desired of any remedy may be obtained from Boericke and Tafel, homœopathic pharmacy, and will be perfectly reliable and true to the label and mark on the cork as to potency, by those who do not care to prepare it for themselves.

There is no power to heal the sick, no force in these potencies, which is not also contained in the crystals of salt, sodium chloride, or natrum muriaticum, but in the crystals it is like a strong man bound by chemical union. By the process of potentiation, succussion (not simply shaking) and trituration the crude substances are so finely divided that they cannot be discovered by either microscope or spectroscope, and thus its benign dynamic forces are set free and able to act on the human organism, beneficially and powerfully and its poisonous qualities are eliminated as in arsenic, belladonna, phosphorus, etc., and these potencies are no longer subject to chemical laws as the crude original substance; phosphorus for instance; sugar globules saturated with a high potency of phosphorus and allowed to dry may be kept in a paper capsule in a drawer for a year and will then still be found to act as phosphorus and not as phosphoric acid.

Here follow some of the symptoms produced by common table salt in the higher potencies when taken by persons in good normal health and also have proved reliable guides to cure the sick. To give all the symptoms thus produced and which have been found thoroughly reliable in healing the sick would fill a book of quite some size. They have been experienced on a great number of provers. No one single person could develop all these symptoms but when a group of these symptoms are present in a patient, potentized salt will positively cure the patient.

The symptoms of common table salt following here were



experienced by persons in good health taking this remedy in the higher potencies to learn its effects on the human organism. It required a number of them to bring out even these few symptoms, for no remedy can effect all persons in the same manner or the same part of the body.

*Mind*—Sadness, weeping with palpitation and intermittent pulse; when trying to comfort him he gets angry and feels worse; gets angry at trifles, hateful, vindictive. Hypochondriacal, tired of life; likes to dwell on unpleasant occurrences. Forgetfulness, loss of memory. Ill effects of disappointment, grief; weeps when looked at.

*Sensorium*—Vertigo on rising from bed mornings, with nausea, colic and trembling of limbs. Trembling after abuse of tobacco.

*Inner Head*—Headache with a sensation as of cold wind blowing through the head. Headache mornings on waking, and moving head or eyes, from mental exertion and warmth; relieved from sitting still and perspiration. Tearing, shooting in the head, as if the head would burst; must lie down. Throbbing in the head evenings; everything becomes black before the eyes on stooping, or moving. Tearing, shooting headache, preceded by obscured vision, face red. Throbbing as from little hammers in forepart of head on waking every morning, worse from reading or talking. Violent jerks or shoots through the head, intermittent pulse, very thirsty. Pain as from a nail driven in left side of head. Headache from root of nose to forehead, with nausea and vanishing sight, worse moving head or eyes. Headache from sunrise to sunset, worse at noon, right eye congested, right-sided headache, comes on at 10 A. M.

*Outer Head*—Hair falls out when touched, more so near forepart of head, white scurf on scalp.

*Face*—Oily, shining as if greasy; face red with headache.

*Eyes*—Black spots before the eyes. Sight dim as if looking through gauze. Eyes give out on reading or writing. Letters run together, look blurred. Styes in corners of eyes. Inflammation of the whites of the eyes with sensation as if the balls were too large; as of sand in the eye. Catarrhal affections of margins of lids, red with burning.

*Ears*—Buzzing, roaring, humming in ears, ringing of bells, chirping. Deafness after quinine. Drawing stitches from ear through neck and shoulders. Painful cracking in ears on masticating.

*Nose*—Profuse nosebleed from stooping or coughing, very liable to take cold. Fluent coryza alternating with stoppage of the nose; loss of smell and taste.

*Face*—Neuralgia recurring periodically, especially after checked ague. Face sallow, great thirst. Upper lip swollen, cracked, rhagades bleeding. Face yellow, pale, wan, pasty. Blisters, single, like pearls around the mouth. Great swelling and burning of lower lip followed by a large vesicle which next day forms a scab. Deep crack in middle of lower lip.

*Teeth and Gums*—Sensitive to warm and cold things, pain in molar bones, worse chewing. Teeth sensitive to air and touch, gums bleed easily.

*Tongue*—One side numb and stiff; children slow in learning to talk.

*Mouth*—Tongue coated with red insular patches; blisters and vesicles on tongue. Painful vesicle on tip of tongue. Profuse watery saliva, salty. Blood blisters on inside of upper lip. Mouth feels dry but is not.

*Throat*—Sensation of a plug in the throat, muscles weak, food goes down the wrong way.

*Appetite and Thirst*—Constant thirst without desire to drink; excessive hunger, especially at supper; feels better when stomach is empty.

*Stomach*—Burning heat rising from stomach. Heart burn after meals. Fainty sinking, gone feeling in epigastrium. Gripping and cramps in stomach, painful to pressure, red spot on pit of stomach.

*Abdomen*—Distended, daily colic, obstructed flatulence. Loud growling in abdomen, viscera feel loose when walking, sensation of heaviness from navel downward with leaden heaviness across bladder and pelvis, tight feeling of skin from hip to hip. Costiveness, stools difficult. Burning in rectum during stool, chronic loose stools. Throbbing and shooting in rectum and anus, anus excoriated. Does not know whether flatus or feces will come; alternating constipation and pape-scent stools; obstinate constipation, unsatisfactory on alternate days. Haemorrhoids with stinging pains, moisture oozing from anus.

*Stool*—Difficult, in balls.

*Urine*—Incontinence, urine comes away when he sat down day or night. Must wait a long time for urine to start, especially if others are near. Violent desire to urinate, in-

voluntary if delayed, or when coughing, sneezing or walking.

*Male Sex Organs*—Great irritability of the sexual instinct with physical weakness. Paralysis after sexual excesses. Itching and excoriation between scrotum and thigh on left side.

*Female Sex Organs*—Aversion to coition, which is painful, great dryness of vagina. Every morning great pressing and pushing toward genitals, must sit down to prevent prolapse. Anxious, sad or headache before, during or after the menses. Menses too late and scanty or too early and profuse.

*Voice and Larynx*—Child is slow in learning to talk; accumulation of transparent mucus in larynx. Ill effects of long speaking.

*Breathing*—Anxious and oppressed, better in the open air, and exercising arms. Attacks of suffocation. Breath hot.

*Cough*—From tickling in pit of stomach, with bursting pain in forehead or beating as of little hammers. Cough worse from rapid motion, deep inspiration, lying in bed or on empty swallowing.

*Heart and Pulse*—Constriction of heart with intermittent pulse with weak faint feeling. Pulsations of heart shake the body. Irregular beat of heart, slow and again quick, missing every third beat.

*Neck and Back*—Throat and neck emaciate rapidly. Beaten, bruised, cutting feeling with pulsation. Pain in small of back as if broken, better from hard pressure and from lying on it.

*Upper Limbs*—Trembling of hands when writing, skin of hands, especially about the nails, dry and cracked; warts in palms of hands and back of hands itching; weariness in arms, fingers are asleep and tingle.

*Lower Limbs*—Trembling of lower limbs on rising from sitting, better on walking. Children slow on learning to walk. Lack of vital warmth, hands and feet cold. Cracks between toes; feet emaciated, tarsal joints of feet feel bruised, twitching of muscles of thighs, limbs restless, must move constantly. Ulcerative pain in feet when touched or on walking, swelling and burning of the feet.

*Sleep*—Sleepy, but cannot sleep; sleepy by day, sleepless at night. Dreams of robbers in the house and will not be convinced to the contrary till search is made.



*Chill*—Fever and sweat; chill with thirst; drinks much at a time and often. Chill begins in the feet and small of the back, at 8 or 10 to 11 A. M., lasting till noon, lips and nails blue, bursting headache, nausea and vomiting. Frequent creeping chills about 5 P. M. followed by heat and sweat.

*Sweat*—With aversion to uncover and thirst, gradually relieving all pains except the headache, which may continue during the sweat. Sweat sour. Intermittents after the abuse of quinine. I have cured more malarial fevers and cured them quickly with this than with any other remedy.

*Skin*—Yellowish color, dry, dirty, livid, shrunken, crackling all over body. Herpes about the mouth, anus and thighs and arms, hands and feet. Moist oozing nettlerash on entire body. Blotches with itching and white scales on scalp. Crusts with deep cracks. Eczema from eating too much salt.

Now if you are honestly desirous of learning the truth of homœopathy take this remedy, *natrum muriaticum* (ordinary table salt) potentized at least to the 30th potency, take it in small doses, frequently repeated and you will see and be surprised at the result. Or try your own preparation on a patient under direction of a good homœopathic physician (for no one can paint a fine picture though he have all the colors, brushes, etc., of an artist, unless he has studied the art of painting) and you will see a rapid and perfect cure effected.

If all doctors would only know and remember—

That the patient must be treated (and not the disease according to its name as when giving antitoxine to every person for diphtheria) and that every patient differs very much from every other one, hence each one may require a different remedy.

That every patient is much more susceptible than a healthy person to the effect of medicine as well as to touch, motion, food or all other influences, and that the graver the disease the less medicine he can stand.

That disease is only a dynamic disturbance of the normal functions of the organism (not a monster) and does not require large doses of powerful and poisonous drugs to combat, and that even after pathological changes have taken place, a very small dose of the proper, indicated remedy will cure the patient.

In short, when all doctors have become strict and sincere homœopaths then few persons will die except of old age or

accidents. Thousands are now dying daily from serums so-called, quinine, digitalis, etc., and mixture of drugs.

"Homœopathy is a law of nature, like gravitation, hence infallible; only the patient or the doctor can fail."

Miss T. M., about 30 years of age, and residing 365 miles from New York City, wrote to me for treatment. When young, 16 to 18 years of age, she had weighed about 135 pounds, but now her weight had been reduced to 90 pounds, from over-work in the household and in an office and a great disappointment. She was very despondent, cried when looked at but became angry if anyone tried to comfort her, the stools were difficult and in small balls like marbles and the menses were scanty and too late. She never had been treated by the old school doctors, but had been under the care of a homœopath in her city without any marked improvement. *Natrum mur.* in various potencies improved her at once so much that in about two months from the beginning of the treatment she had gained 35 pounds, feeling again in good spirits, and with the aid of a few other remedies like phosphorus, *pulsatilla*, sulphur she soon was restored again to normal health.

This patient had taken salt in her daily food during all the years of her illness, yet it did not cure her, but salt, *natrum mur.* 45m did this quickly.

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### SOME NINETEENTH CENTURY GIANTS IN MEDICINE.

BY

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(Read before the Missouri State Homœopathic Medical Society.)

FIRST of all and greatest of all is Samuel Hahnemann, who was born in Meissen, Saxony, April 11, 1755, and died July 2, 1843. In 1810 he published in Dresden the first edition of his celebrated *Organon of Rational Healing*.

Dr. Timothy F. Allen said, "While it is not true that Hahnemann was the first to announce the homœopathic method since Hippocrates long before the Christian era, distinctly stated that some diseases may be cured by the 'law of similars' while others were cured by the 'law of contraries,' yet Hahnemann is as much entitled to be termed the discoverer of

homœopathy as though Hippocrates never had promulgated this law." Hahnemann evidently apprehended the truth of the "law of similars" independently of Hippocrates, who lived in the fourth century B. C., and what is of vastly more importance, Hahnemann immediately proceeded to fortify himself by investigation into the records of the past, and when thoroughly convinced, at once began to investigate the properties of drugs in order to make the application of the law possible and universal. Hahnemann discovered that each substance, particularly each drug, possesses a "spirit-like force" which can be liberated by dynamization. Before the era of molecular physics and atomic chemistry, Hahnemann demonstrated that substances absolutely identical as to atomic constitution possess quite different physical as well as medicinal properties when the molecules or atoms are differently grouped. This constitutes the "spirit-like force" of a substance as conceived by Hahnemann and since verified by thousands and thousands of his followers the world over. Our present knowledge of chemistry or physics does not, in any way, disprove Hahnemann's discovery. The clinical investigator has satisfied himself over and over again each day of his professional experience that the "law of similars" is true and that the spirit-like force of a drug is liberated by dynamization. The clinician led the way in medicine through the ages and the laboratory investigator followed slowly—but a long way behind. It may be that chemistry or physics will sometime demonstrate the truthfulness of this "spirit-like force" in the dynamization of drugs.

As the eighteenth century closed and the nineteenth century began, there was only one brilliant star visible on the medical horizon. The therapeutic leaders of past centuries were hidden by clouds of gross empiricism and ignorance. As we look back on those times, we can see the name of no one who did as much for the medical world as Hahnemann did. As far as therapeutics is concerned, we can see no one but Hahnemann and his followers in the early part of the nineteenth century. All the practitioners of medicine of those years, except Hahnemann and his followers, went down to oblivion in the mire of empiricism and were forgotten. It seems that Hahnemann was divinely chosen to lead the whole medical world into the promised land of scientific therapeutics. He was the Moses who was chosen by Almighty God to lead the misguided medical hosts out of the wilderness and in doing



this he had as much trouble as the leader of the Children of Israel had, in preventing his followers from going astray and worshipping false gods. Even to this day some of those who graduated in homœopathic colleges and joined homœopathic societies have gone off after the false gods of allopathy. They have joined the American Medical Association and other old school medical societies and ended up as veritable medical reprobates—not worthy of the respect of anyone—not even the old school doctor. God hates a quitter and every true homœopathic physician would rather be crucified than forsake his principles and join the crowd that has no respect for God's natural law. "And Jehovah said unto Moses, Whosoever hath sinned against me him will I blot out of my book. And now go, lead the people unto the place of which I have spoken unto thee; behold mine angel shall go before thee; nevertheless in the day when I visit I will visit their sin upon them. And Jehovah smote the people because they made the calf which Aaron made."

In 1820 Hahnemann was forbidden to dispense his own medicine in Leipzig and was driven from his home. Although extremely poor, he did not renounce his belief in homœopathy that he might obtain a support for himself and family. He found an asylum with Ferdinand—the reigning Duke of Anhalt-Coethen—where he resided fifteen years and then moved to Paris where he acquired an enormous reputation and practice. The homœopathic system was a revolution in therapeutics; it spread with the greatest rapidity and was adopted with avidity by the most cultivated physicians of Europe.

January 1, 1800, in Oschatz, Saxony, Constantine Hering was born. He became a diligent student of Hahnemann's proclaimed doctrine—*Similia Similibus Curantur*—when Prof. Roby of Leipzig, called upon young Hering to engage in a controversy to combat and defeat Hahnemann's theory and teachings of the system of homœopathy. The result was contrary to his expectation and the hopes of others. Hering was called upon to make a post mortem in the case of a suicide whose body had been taken from the grave. A cut on Hering's finger, which had scabbed over, became denuded; infection set in and in a few days the finger began to mortify. Leeches, calomel and hell stone proved powerless. Amputation was declined. It was the first finger on the right hand. Hering said, "I was persuaded by a student of Hahnemann to take ridicu-

lously minute doses of arsenicum. When the various symptoms of recovery from this terrible affliction began to pervade me, there vanished the last obstacles interposed between my eyes and the rising sun of the new healers. The finger is my own, it is the one with which I pen these lines." "To Hahnemann who restored it was given the hand, even more the man, body and soul." "His teachings had not only been the means of saving my life, but new life filled my very soul."

From Leipzig young Hering went to Wurzburg where he obtained his degree of Doctor of Medicine with highest honors in 1826. He took a position as Instructor in Natural History and Mathematics in the Institute of Blochman in Dresden. Soon he was sent by the Saxonian Government with his friend, Weigel, on a scientific expedition to Surinam to take charge of zoological and botanical researches. In addition to his duties there, he labored in the midst of cholera and leprosy among the natives, Indians, negroes and whites. He was reprimanded and warned by his home government to stop the further practice of homœopathy. Knowing that he was disliked in his home, he resigned his position as an officer of the Saxonian Government and began the practice of homœopathy in Paramaribo.

Young Hering had heard much about the United States and in 1832 decided to leave Paramaribo and his German Moravian Colony and become a citizen of Philadelphia, where he landed in January, 1833—having left his Moravian friends a work of 450 pages containing a list of 66 remedies, together with the symptoms of diseased conditions to which they were applicable. Dr. Constantine Hering lived and practiced homœopathy in Philadelphia from 1833 to July 23, 1880, when he died. He wrote books and pamphlets and distributed homœopathic knowledge freely throughout the world. He was indefatigable in his labors and finally became the pillar of homœopathy—the Hahnemann of America. His greatest work and his last was "Guiding Symptoms of our Materia Medica" in ten volumes. Although Dr. Constantine Hering was greatly persecuted in his early professional career, he never turned traitor to his convictions of truth and finished his course, as he began, with the approval of his conscience and his God. "Well done, thou good and faithful servant, thou hast been faithful over a few things, I will make thee a ruler over many things. Enter thou into the joy of thy Lord." Voltaire said, "Men

who are occupied in the restoration of health to other men by the joint exertion of skill and humanity are above all the great of the earth. They even partake of the divinity since to preserve and renew is almost as noble as to create." Since Hering died, an entire generation of younger practitioners have entered the medical field and of many of them it may be said as of the ancient kings of Egypt, "They knew not Joseph."

E. A. Farrington was born January 1, 1847, and died December 17, 1885. He was a teacher among men. He graduated at the Hahnemann Medical College of Philadelphia in 1868. He began teaching in this college in 1869 and in 1874, upon the resignation of Dr. Guernsey, then Professor of *Materia Medica*, Farrington was called to fill that most important chair. His delight lay in the study of *materia medica*. He daily associated with Hering, who quickly recognized him as one well fitted to rank among the greatest expounders of that most intricate science—*materia medica*. Hering delighted to say, "When I am gone, Farrington must finish my *materia medica*." We find him as a beginner in years, almost a master of the *materia medica*. He did not write massive volumes; he condensed what he learned into valuable articles, or lectures, which were finally published together in 1887—two years after his death—in one volume—a *Clinical Materia Medica*—a *vade mecum* for students of medicine for ages to come.

H. C. Wood, M.D., LL.D., was Professor of *Materia Medica* and Therapeutics and Clinical Professor of Diseases of the Nervous System in the University of Pennsylvania from 1875 to 1894, during which time he published his *Therapeutics*, which went through nine editions. He was considered by the old school doctors a giant in medicine in those days. He said, "Experience is the mother of invention. Verily she has been in medicine rather a blind leader of the blind; and the history of medical progress is a history of men groping in the darkness; finding seeming gems of truth, one after another, only in a few minutes to cast each back to vast heaps of forgotten baubles that in their day had also been mistaken for verities. In the past there is scarcely a conceivable absurdity that men have not tested by experience and for a time found to be the thing desired." "Narrowing our gaze to the regular profession and to a few decades, what do we see? Experience teaching that not to bleed a man suffering from pneumonia is to con-



sign him to an unopened grave, and experience teaching that to bleed a man suffering from pneumonia is to consign him to a grave never opened by nature." Looking at the revolutions and contradictions of the past—listening to the therapeutic babel of the present—is it a wonder that men should take refuge in nihilism, and like the lotos-eaters, dream that all alike is folly? That rest and quiet and calm are the only human fruition." "In spite then of Dr. Niemeyer's assertion that experiments made with medicaments upon the lower animals, or upon healthy human beings have, as yet, been of no direct service to our means of treating disease, and that a continuation of such experiments gives no prospect of such service, it is certain that in these experiments is the only rational scientific groundwork for the treatment of disease." This frank statement by Prof. H. C. Wood covers the whole field of allopathic therapeutics to the present time and confirms Hahnemann's method of proving the effects of drugs on healthy persons to learn how to use them in the treatment of disease.

Dr. Henry N. Guernsey, of Philadelphia, was for eight years Professor of Obstetrics and Diseases of Women in the Homœopathic Medical College of Pennsylvania and published a book in 1873 of 1,000 pages on "The Application of the Principles and Practice of Homœopathy to Obstetrics and the Disorders Peculiar to Women and Young Children." That book went through several editions and from its first year of publication to the present time, it has been a gold mine of medical nuggets that all students and practitioners of homœopathy have eagerly sought and used with the greatest success in their treatment of all ailments of women and children. Had Guernsey done nothing more for humanity he might have died with the positive assurance that the book itself would be an everlasting monument to his memory. In 1871-2-3 he was Professor of Materia Medica in the Hahnemann Medical College of Philadelphia. In 1886, after his death, there was published a thoroughly practical materia medica of 267 pages containing characteristic symptoms and "key notes" of the principal remedies that he had written up during the last two years of his life. He was surely one of the giants of the nineteenth century in medicine and every homœopathic physician should hold Henry N. Guernsey in grateful remembrance. Whenever I hear of the apostasy of some graduate of a homœopathic

medical college, I know that the said apostate did not have the mental equipment to understand the homœopathic materia medica or else he was hopelessly without a quickened conscience, or that he was too lazy to make the necessary exertion to dig into his repertory and his materia medica for the homœopathic remedy in each case. I would not call him back. He is worthless! Let him go! Extend the helping hand to the young enthusiastic persons who have been converted soul and body to the homœopathic law and to the homœopathic treatment of human ailments as taught by Hahnemann, Hering, Farrington, Guernsey and others, and are not liable to be turned back by mercenary appeals or allopathic persecution. Throughout the entire world today, one may find young doctors of medicine following in the footsteps of the great homœopathic masters. Everywhere one goes he meets medical derelicts of all kinds who have lost faith in everything and freely predict the downfall of all medical theories, including homœopathy. Truth though crushed to earth will rise again, and to the end of time the law of similars will live. Today, the main obstacle to medical unity is the recognition of this law of similars and not until this obstacle is removed will there be any peace in the medical world. The mission of the homœopathic school of medicine will be accomplished when the life-giving impulse of similia is mingled with the other currents of therapeutics and the homœopathic law is universally acknowledged as the main principle of the healing art. In the twentieth century we may come very near to a world-wide recognition of the natural law *similia similibus curantur* and a united medical profession, but that time will not arrive until the allopathic hosts, the eclectics, the osteopaths, the so-called Christian Science Healers, the chiropractors and all other special kinds of healers have surrendered all opposition to the whole truth as taught by Hahnemann. The uprooting of quackery can be accomplished only by a united profession, but we will never have a united profession if the followers of Hahnemann fail to maintain their independence and join the American Medical Association and other old school societies. The fight must go on till every knee shall bow and every tongue confess that the law of similars is true. The benighted medical hosts must come up to us, we cannot go down to them. "Right is right since God is God and right the day must win. To doubt would be disloyalty. To falter would be sin."

I have on my desk Dr. G. H. G. Jahr's Dictionary and Concordance of Homœopathic Practice, translated by Dr. Charles J. Hempel of New York, and published in 1849. It is a clinical guide and repertory for the treatment of acute and chronic diseases, and I consult it daily. In 1869, Dr. Samuel Lilienthal of New York, assisted by Drs. Guernsey and Raue of Philadelphia, Dr. Wells of New York and Drs. Franklin and Helmuth of St. Louis, published a revised and enlarged edition of Dr. Jahr's book. It was a wonderful revelation of the homœopathic treatment of acute and chronic diseases and the indications for remedies given in that book have stood the severe tests of more than fifty years and still faithfully guide the practitioner today. Can you say as much for any work on therapeutics and materia medica published fifty years ago by any old school author? The average life or demand for any old school work on therapeutics or materia medica is not over five to ten years at the best. After that time it must be discarded as worthless. Some second-hand bookstore may pay fifty cents or a little more for it. Homœopathic books, although one hundred years old, are always in demand and are worth 100 cents on the dollar at all times.

In the short time of thirty or forty minutes, I cannot speak of each one of the hundreds of medical giants of the past century. Thousands of very bright men of the so-called regular school of medicine have strenuously pursued the study of drugs and accomplished very little in the way of therapeutic advancement. Therapeutics and materia medica, as far as the old school is concerned, have gone into the discard and are not much taught in any old school medical college today. X-ray, serum therapy, the administration of animal products, electricity, salvarsan, neosalvarsan, vaccines of all kinds, manual therapeutics, proprietary preparations of many kinds and anything and everything in the line of drugs constitute the armamentarium of the average old school doctor and medical nihilism was never more general than it is today.

In Kansas City, where I live, there are about 1,300 men and women who earn their living by the practice of what little medicine they know, and this does not include over 150 Christian Science Healers. Many of them are not worthy of the confidence of their patrons, and could not exist were it not for the remarkable credulity of the general public. Dr. O. S. Haines of Philadelphia, says, "While it may surprise some of



you to hear it, I do believe it would be a good plan to again offer this method of similia to the profession as one of the distinct advances in the therapeutic art." "Present the method of similia once more to the homœopathic profession alone." "This method is in reality one of the advanced outposts along the line of march which the therapeutic art is taking."

Let the homœopathic men and women wake up and re-discover homœopathy, and not permit the faithful investigators of the old school to steal our valuable treasures while we sleep. Quietly thousands of allopathic physicians are today studying homœopathy and are publishing what they learn as recent investigations of their own. Just now they are giving great attention to vaccine therapy and believe that it will be the salvation of modern medicine. Dr. Alexander Francis says, "Few things produce a more harmful effect upon the system as a whole than vaccines. A vaccine may give relief in a specific instance, but even then it is at the expense of the system generally, and the continued use of vaccines does incalculable harm." The same is true of salvarsan and neosalvarsan. I can only speak of a few of those who have been widely and favorably known in the nineteenth century in the homœopathic medical profession.

Dr. Richard Hughes of England, was an eminent and systematic writer who enriched and illuminated our *materia medica* in his *Pharmo-Dynamics*.

Dr. Carroll Dunham's lectures presented to the student of *materia medica* a picture of each remedy so well that he could not forget it. Lippe's Text Book and Hempel's Lectures on *Materia Medica* were my first text books in 1872 and are worth the careful study of the prescriber today.

Dr. Timothy F. Allen of New York, was one of the greatest teachers of the *materia medica* in the past century and his *Encyclopedia of Pure Materia Medica* will stand as an authority on the subject through the centuries to come. Allen's Handbook is a valuable aid to the practitioner.

Dr. A. C. Cowperthwaite succeeded in presenting in his Text Book of *Materia Medica* and Therapeutics the characteristic points of remedies. This book passed through eleven editions and will remain an excellent guide to the busy practitioner. About fifty years ago, Dr. George S. Norton of New York, a pioneer in ophthalmic therapeutics, published his book giving the indications for homœopathic remedies in the treat-

ment of all diseases of the eye. After his death his brother, Dr. A. B. Norton, enlarged the work and published a book on Ophthalmic Diseases and Therapeutics which was gladly received by the medical profession and passed through several editions.

Drs. William Boericke and W. A. Dewey did much for the medical profession over thirty years ago in the publication of their work on the Twelve Tissue Remedies of Schüssler, and since that time each one of them has rendered invaluable service to mankind in books on *materia medica* and therapeutics, which are now standard authorities.

From 1880 to 1890 Dr. Charles Gatchell of Chicago, and Dr. I. D. Johnson of Kennett Square, Pa., each published a pocket manual on Medical Practice and Indications for Remedies. These books were of great help to the young practitioner and the laity too.

In 1887 Dr. Charles F. Millspaugh, a pupil of Dr. Timothy F. Allen, published two large volumes on American Medicinal Plants, an Illustrated and Descriptive Guide to the American Plants Used as Homœopathic Remedies. This work contains 180 colored illustrations and complete text of all the proven plants indigenous and naturalized in the United States. The author in every case drew and colored the plants represented in this work by his own hand from the specimens as they stood in the soil. No other work of equal merit was ever published before or since 1887. He gave under the description of each plant the physiological action and the actual toxic effect of it. The two volumes are real works of art and will be kept as treasures by everyone who has them.

Emerson said, "For a time our teachers serve us personally as metres or milestones of progress. Once they were angels of knowledge and their figures touched the sky. Then we drew near, saw their means, culture and limits, and they yielded their places to other geniuses." "Great men exist that there may be greater men." "The destiny of organized nature is amelioration and who can tell its limits? It is for a man to tame the chaos; on every side whilst he lives to scatter the seeds of science."

Nature never sends a great man into the world without confiding the secret to another soul, and it is foolish to think that a great man's place cannot be filled by another, perhaps more than filled.

Isaac Newton discovered a great natural law—"Every body in nature attracts every other body with a force directly as its mass and inversely as the square of its distance." This law was carefully investigated by Maskelyne, Cavendish, Bailly and Herschel, who found that the law was not only true but that it was much more universal than Newton had ever dreamed of.

Benjamin Franklin discovered the nature of lightning, Samuel Morse went further and invented the telegraphic instrument. Alexander Bell went still further and discovered the telephone. G. Marconi profited by their discoveries and we have now Marconi's system of wireless telegraphy, and the great Creator only knows what is coming next.

Samuel Hahnemann discovered the law of similars, but did not live to find out the extent of his discovery. Thousands of investigators have followed him and Constantine Hering and just now the whole therapeutic world is giving a very careful examination of the law of similars. The effects of drugs, the action of electricity and the action of everything in the heavens above and the earth beneath on the animal kingdom, are to be more closely investigated with the intention of taking a very careful inventory of the great mass of symptoms already accumulated, and trying to find out, if possible, where Hahnemann's law of similars begins and ends.

Samuel Hahnemann also discovered the corollaries of homœopathy—the decimal or centesimal attenuation of drugs, the single remedy, the minimum dose, the infrequent repetition and the totality of the symptoms required in the selection of the remedy.

These deductions naturally followed the proved proposition and it is along this line that the vanguard of modern orthodox medicine today is approaching homœopathy.

In 1835 Dr. Samuel Hahnemann published his second and enlarged edition on *The Chronic Diseases, Their Peculiar Nature and Their Homœopathic Cure*. Only forty-eight medicines are mentioned in this work. All of the provings of these remedies up to that time were recorded by him.

In 1879 the first volume of *Guiding Symptoms* was published and the tenth volume was published in 1891. In these ten volumes we have the complete provings of about 368 remedies.

Dr. William Boericke of San Francisco, in his seventh



edition of his materia medica gives brief provings of about 1300 remedies. It is now up to the medical men and women of the twentieth century to faithfully revise new remedies coming from God's vast universe. The immensity of the task before us should not frighten us. We may be sure that there are still thousands of remedies in nature that we know nothing about as yet, and there will be need for faithful investigators and provers in the centuries to come. We need now thousands of such men as Hale, Allen, Hoyne, Lilienthal, Helmuth, Franklin, Dowling, Thomas, Raue, Hawkes, Baehr, Clarke, Kippax, Boenninghausen, Goodno, Ludlam, Pope, Pulte, Arndt, Hartman, Smith and hundreds of other medical giants of the nineteenth century.

Some do not believe that in the twentieth century or in several centuries there will be so many medical giants and that the advancement in therapeutics will be as great as it was in the nineteenth century. The American Institute of Homœopathy has a membership of several thousand, and there are hundreds of them who are qualified by nature and training and devotion to the cause to take up the work of revising the materia medica and discovering new remedies. They will surely make some great discoveries before this century is past—perhaps as great as any that have been made.

In closing I will add the opinion that the progress of future research will tend not to diminish or decrease the importance of the law of similars but to enhance and glorify it, and the labors of Hahnemann who discovered it and thousands of men and women of the nineteenth century who so ably assisted him in promulgating it.

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#### AURUM MURIATICUM ET NATRONICUM.

BY

CRAWFORD R. GREEN, M.D., TROY, N. Y.

AN interesting editorial note upon the much neglected remedy *aurum* appeared in the June number of THE HAHNEMANNIAN MONTHLY. This editorial note is very valuable and very suggestive, but I am greatly surprised that it fails even to mention the remedy in connection with high blood pressure or with arteriosclerosis; for in both high blood pressure, the

symptom, and arteriosclerosis, the disease, it is a remedy of the very greatest importance. It is on this account that I am prompted to make these preliminary notes upon a subject upon which I hope later to make a much more detailed report.

I have been studying the effect of *aurum muriaticum et natronicum* upon patients with high blood pressure for the past ten years. I have prescribed it for many patients with results that are among the most gratifying of all that I have attained in the practice of internal medicine.

The patients to whom this remedy seems to be particularly adapted fall mainly in two classes:

(1) Women at or just past the menopause, who, in connection with the nervous symptoms so commonly experienced at this period, present a blood pressure considerably above the normal. These patients present the common functional disturbances that accompany the menopause, and their high blood pressure is usually the result not of organic change but rather of disturbed function of the nervous mechanism. These cases are extremely common, their symptoms are distressing but not alarming, and in *aurum muriaticum et natronicum* they may find relief that is surprisingly prompt and almost certain in its results. In connection with this class of cases, it should be remembered that the provings of *aurum muriaticum et natronicum* have adduced many symptoms referable to the uterine sphere.

(2) The true arteriosclerotic of advanced life. This is by far the most interesting of the two classes because results in these cases are not so likely to be expected and yet they are met with so frequently that, in view of our previous ideas of the disease, they seem almost miraculous. I have seen case after case in which *aurum muriaticum et natronicum* was administered for considerable periods of time relieved and to all appearances cured after all the common remedies such as the iodides and the nitrites had completely failed to make any impression. Patients with a long standing systolic blood pressure of 200 or over with marked dizziness, formication, dyspnoea, polyuria, depression and nervousness, have been entirely relieved of their distressing symptoms and have acquired and retained a normal blood pressure. Others, particularly those with a hypertrophied heart, have had but little reduction of blood pressure, but have been markedly alleviated from unpleasant symptoms.

For example, a patient about 55 years of age consulted me first about five years ago with a systolic blood pressure over 200 and suffering with vertigo, formication, dyspnoea, and all the other distressing symptoms of high blood pressure. She had frequent crises when she seemed about to have a cerebral haemorrhage—crises which were called arterial spasms. She was given *aurum muriaticum et natronicum*, third decimal triturated tablets, in doses of one grain four times daily. The symptoms slowly but steadily improved for three years, during which time she took the remedy with persistent regularity. At the end of three years the blood pressure was normal and there was a complete cessation of all the symptoms. For the past two years I have taken this patient's blood pressure on an average of once a month, as a precautionary measure, and, in the absence of all pressure reducing medicine, not once has there been the slightest elevation above normal.

Another patient, a woman now nearly 80, has had a systolic blood pressure ranging from 200 to 260 during the past ten years. She has a hypertrophied heart but, notwithstanding her age and her condition, she goes about considerably. She has taken *aurum muriaticum et natronicum* during most of the ten years but, because of her heart, the blood pressure has been but little, if any, reduced by the treatment. The interesting fact about this patient is that while the systolic blood pressure is irreducible, the symptoms resulting from it are influenced by the remedy. This is incontestably demonstrated by the fact that giving up the remedy for varying periods, as the patient has done from time to time, is invariably accompanied by a recurrence of vertigo, formication, and dyspnoea, which are, in turn, quickly relieved by a return to the remedy. I have taken pains to establish the fact that this is not merely a psychical effect of varying the form in which the remedy is administered. This is not an isolated case, for I have seen similar results in a considerable number of other cases; but until recently I have been at a loss to understand how the remedy exerts its action to relieve these symptoms when the cause of the symptoms still exists.

In what way, then, does this remedy so profoundly affect these cases? It is my belief that *aurum muriaticum et natronicum* exerts some as yet unexplained direct physiological or chemical effect upon the degenerative changes taking place in the arteries so as to retard any further damage, and, perhaps,



even to undo some of the damage that has already been done. The likelihood of the existence of such an action is borne out by the fact that in unquestioned cases of arteriosclerosis with a hypertrophied heart, while the systolic pressure remains high because of the powerful contractions of the enlarged heart, the diastolic pressure, which depends upon the arterial resistance, has been gradually lowered with the continued administration of the remedy in those few cases that have been studied from this viewpoint. It is easy to conclude from this that the common subjective symptoms of high blood pressure are due not to the systolic pressure, but to the diastolic. In this way, one can account for the disappearance of the symptoms of arterial disease, even though the systolic pressure remains high. This conclusion is further borne out by the testimony of a colleague who specializes in electro-therapy. He informs me that he has had many cases in which the symptoms were relieved by auto-condensation treatment when the systolic pressure was not lowered. He has made no study of the diastolic pressure.

It is unfortunate that the relation between the systolic and diastolic pressures has not been observed in those patients who have taken *aurum muriaticum et natronicum* over a period of years; but it is only comparatively recently that the importance of the diastolic pressure has been demonstrated and the true relationship of the systolic and diastolic pressures emphasized.

I appreciate the meagreness of these notes from a scientific standpoint. They are presented not with any thought that the exposition can be accepted as in any sense conclusive, but as a sort of foreword to the investigations that I am making at the present time. From these investigations, I hope soon to be able to present the histories of a series of cases that will be sufficiently accurate to be of definite value. If the promise which *aurum muriaticum et natronicum* holds out can be fulfilled, we have in this remedy an efficient help in the treatment of one of the most distressingly chronic, dangerous, and otherwise intractable conditions with which we have to deal.

I have used the remedy in both the second and third decimal triturations. At the present time, I favor the second in true arterial sclerosis and the third in cases that are purely functional. The dose has varied from one grain every four hours to one grain twice a day.

**REPORT OF A CASE OF EMPYEMA OF UNUSUAL SIZE AND SYMPTOMATOLOGY.**

BY

CLARENCE BARTLETT, M.D., PHILADELPHIA.

(Presented to the Philadelphia Clinico-Pathologic Society, January 5, 1920.)

ON June 23rd last, Dr. M. J. Nevinger requested that I examine a Mr. S. at his residence. The patient was a well built man, aged about 56 years. His health had always been of the best until he was taken with an attack of influenza in December, 1918. He made a fair recovery, but complained of a heaviness of the feet. This increased in severity, until finally it assumed a character described by him as resembling a pair of flat irons fastened to his shoes. He then consulted a well-known internist of Philadelphia, one noted for the pains-taking care and accuracy of his examinations. This was in January, 1919. The diagnosis given at this time was left sided pleural effusion. Several exploratory punctures were made, one of which succeeded in removing an ounce of a clear fluid, afterwards determined to be sterile. The patient himself was disgusted with the opinion given him, and illogically stated his feeling, "I called upon the doctor to cure my feet; but he wanted to treat me for my chest." The patient accordingly changed medical advisers, going from one to another, his condition growing gradually worse in the meantime. Finally, in June, Dr. Nevinger was brought into the case, and invited me to consult with him concerning the illness.

The patient at this time was almost completely paraplegic, the paralysis being of the spastic type. He was just about able to walk. Knee jerks were grossly exaggerated; ankle and patellar clonus were present and persistent. Babinski phenomenon was typical. In addition to the paraplegia, the patient was intensely dyspnoeic, the respiratory disturbance showing the cardiac type.

Physical examination showed absolute flatness of the entire left chest with well defined tubular breathing, loud transmission of the whispered voice, and pronounced sense of resistance of the left chest to palpation. The heart was displaced to the right. The diagnosis of large pleural effusion was made and paracentesis advised and refused by the patient and

the family. Two days later, there was a change of mind, and the patient was removed to the Women's Homœopathic Hospital, where I aspirated, the total amount of fluid removed being 4,750 c.c., or not quite five quarts. When about 500 c.c. had been aspirated, the patient complained of a feeling of faintness. The operation was then suspended for a few minutes, and then aspiration was resumed but was proceeded with slowly by withdrawing for 10 seconds, and then permitting an interval of from 10 to 20 seconds to intervene. At the end of 1,000 c.c. the patient expressed himself as feeling very much better. Accordingly the aspiration proceeded until the chest was emptied. Dyspnoea disappeared completely. The paraplegia improved until the patient was able to walk with comparative ease. Operation was advised, but refused. General improvement was so great that the patient proceeded to Atlantic City and remained there a few weeks, coming home as bad as before in the latter part of July. The lower limbs were now deprived of all motor power. Dyspnoea was again intense. Aspiration was performed, but on the withdrawal of 1,500 c.c. the patient felt faint, and the procedure was discontinued.

Two days later Dr. G. A. Van Lennep performed a rib resection. The patient was in poor condition for a few days, but shortly began with a convalescence that was uninterrupted. The paraplegia remained absolute for one week, when it began to disappear slowly. After six weeks, the patient had made an apparently perfect recovery, and it was arranged that I should visit him to report him as able to dismiss his nurse and to take part in the world's affairs. That morning at 3 o'clock he aroused from sleep with a choking sensation, and before assistance could reach him he was dead.

I regret exceedingly that no autopsy was performed. I must also apologize for the superficial character of the report. The interesting features of the case are first the large size of the empyema, which, so far as I know, is a record for the left side of the chest; and the associated paraplegia of spastic type. My experience and reading have not enabled me to associate the empyema and the paraplegia, and yet the association seems to be clear by reason of the two occasions on which it improved promptly following the removal of pus from the chest. The suggestion that it was hysterical is worthy of thought, but I do not believe will bear much importance. The



persistent patellar and ankle clonus and the typical double Babinski would make negative the hysterical hypothesis, aside from the fact that the paraplegia did not partake of hysterical features, and the patient had never been hysterical. It is unfortunate a post-mortem examination was not permitted.

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## UNRECOGNIZED FOCI OF INFECTION IN THE NOSE AND THROAT.

BY

WILLIAM G. SHEMELEY, JR., M.D., PHILADELPHIA, PA.

(Read before the West Jersey Homœopathic Medical Society, Camden, N. J., May 19, 1920.)

EVERY practitioner of general medicine has under his care many cases of peculiar arthritic, neuritic or other chronic conditions that resist the most careful and detailed methods of treatment. This class of patients, after a period, develops into the so-called chronic type, often suffering from acute exacerbation and never entirely free from symptoms. The prevalence of chronic disease of one or more of the accessory sinuses of the nose, which has long been unrecognized in these cases, is well-known to all rhinologists.

That pus, concealed in any cavity, is capable of producing peculiar and persistent conditions not entirely referable to the sinuses is conceded by all. The fact that the sinus disease has developed and remained unrecognized while the patient was under the care of the general medical man, would seem to be due not so much to his lack of knowledge but first, to his inability to apply that knowledge, and second, his failure to recognize certain clear-cut symptoms.

Of course, there is a reason for this. The general medical man, because of the small fee he receives, is not always able to devote the time necessary to accomplish the best results.

Probably 70 per cent. of those having disease of one or more of the accessory sinuses remain undiagnosed for an indefinite period. Of the remaining 30 per cent., at least 20 per cent., although recognized, have not received the proper treatment. The 10 per cent. properly diagnosed and treated will give about 8 per cent. of cures, leaving 2 per cent. that show only relief or no improvement.

The possibility of prophylaxis of chronic conditions resulting from the causes just mentioned as well as the beneficial results from a curative standpoint will depend upon the early recognition of the sinus disease and the institution of proper treatment.

As an aid to the early recognition of sinus disease, every practitioner of medicine should have a working knowledge of the simpler instruments used in the examination of the nose and throat.

They should include the use of :

1. Head mirror.
2. Nasal speculum.
3. Probe and applicator.
4. Tongue depressor.
5. Pillar retractor, to determine presence or absence of secretion in tonsils; besides he should possess a knowledge of the technique of puncture of the maxillary sinus.

Having familiarized himself with the use of these instruments the physician next wishes to know what should be sought for in these various accessory sinus conditions.

That he may be able to do this in an intelligent manner he should improve every opportunity to examine the nose and throat. In this way only can one familiarize himself with their anatomical topography.

A patient comes to the physician suffering from an acute cold. A sense of stuffiness of the nose is complained of, together with headache referred to the region of the frontal sinuses. The degree of temperature is variable. If the physician will adjust his head mirror in order to secure good illumination and examine the nose he will probably find :

First—The mucous membranes of the nasal tract are swollen and engorged with blood.

Second—At first there will be little or no secretion, the mucosa will appear hot, turgid, dry and rather glazed. At a later stage pus of a creamy character will appear, which, if wiped away immediately reappears between the middle turbinate and lateral wall—except in cases of so-called locked-up type.

In either of these stages the general practitioner can accomplish a great deal by the use of a few simple and easily applied measures.

With a nasal applicator make three applications of a 20

per cent. solution of cocaine to the region between the middle turbinate and lateral wall at intervals of three minutes. Then twist some cotton loosely into a small tampon, saturated with 15 per cent. aqueous solution of argyrol and introduce into the nose, placing it, if possible, between the middle turbinate and the lateral wall. The tampon should be allowed to remain *in situ* for about fifteen minutes and then removed. The physician should secure free catharsis and prescribe the indicated remedy.

This nasal treatment should be used daily, at first, and as the discharge begins to lessen a treatment every other day or every third day will suffice.

The time consumed in this simple form of treatment is negligible compared to the beneficial effects obtained and your patient will thank you for the relief afforded. This class of cases, untreated, will go on to spontaneous recovery in the great majority of instances; however, the attack will have served as the beginning focus of a chronic frontal sinusitis, with its long train of associated conditions.

**MAXILLARY SINUS.**—Recalling topographical and general anatomy of the maxillary sinus you will remember that it can best be likened unto a pyramid, the lateral wall of the nose forming the base, the apex being at the junction of the malar with the superior maxillary.

The boundaries of this pyramidal cavity are, above, the orbital plate of the superior maxillary, anteriorly, the canine fossa, and posteriorly the pterygo-maxillary fossa. The base is formed by the maxillary process of the inferior turbinate, a portion of the palate bone, the uncinatè process, the lamella of ethmoidal bulla, and the pars membranacea; all of which form the lateral wall of the nasal cavity. The most important of these boundaries is the nasal wall of the maxillary sinus, because it contains the only opening into the antrum, and is the first to show definite changes when the sinus is diseased.

Because it is the thinnest, it presents the easiest method of attacking the cavity either for diagnostic or therapeutic reasons.

The maxillary sinus is found to be diseased more often than the other sinuses, for the reason that it has, in addition to the usual causative factors of sinus disease, the intimate relation of its floor to the teeth.



The general medical man should ever bear in mind that the two most common causes are:

- (a) Direct extension from the nasal mucosa (coryza).
- (b) From teeth (contiguity from blood) (continuity-bone).

When in the course of coryza or influenza the patient complains of feeling of distention and pressure, and pain referable to the region of the maxillary sinus, together with periodic discharge of pus from the side of the nose that corresponds to the sinus suspected and which gives relief from pain and sense of pressure, the physician is correct in presuming that the patient has a pathological process of the maxillary sinus.

Two methods of procedure are available: The patient may be radiographed, this serving at the same time to exclude the other sinuses, or a puncture of the maxillary sinus may be performed and the cavity washed.

A combination of the two methods will, no doubt, prove the best. The washing of the maxillary sinus may be repeated daily at first, then the interval lengthened as the condition improves.

**TECHNIQUE OF PUNCTURE OF MAXILLARY SINUS.**—With a small cotton wound probe and a solution of 20 per cent. cocaine secure thorough shrinking and anesthesia of the lateral wall of the nose by applying the solution to the region beneath the inferior turbinate. Having tested the insensibility, a needle is inserted beneath the inferior turbinate, about 3 cm. from the anterior margin, the bone being thinnest in this region. A piece of small calibre rubber tubing should be firmly fastened to the proximal end of the needle. With a good syringe force air through the tube and listen for the sound emerging from the ostium. If it is dry and whistling in character it is unlikely that the sinus contains fluid; on the other hand, if the sound is moist and bubbling, associated with an unpleasant odor, an empyema of the maxillary sinus is present.

Next syringe with water and bi-carbonate of soda, a teaspoonful of soda to one pint of water at body temperature. Have the patient incline the head forward and breathe through the mouth. The washings should be collected in a dark receptacle because the character of the discharge can be better observed. Following this use argyrol tampons as described under frontal sinus condition. Then the indicated remedy. What an advantage the general medical men have over those

who specialize! To the general practitioner the *materia medica* is an open book. He approaches the subject from every angle of the patient's general condition and symptoms which those who specialize are less able to do, except those who have previously practiced general medicine.

The problem of disease of the ethmoids and sphenoids is hardly one to be undertaken successfully by the general medical man, and since it has been the author's plan to speak of the simple accessory sinus conditions that could and should be treated by him, the more complex processes were omitted.

**TONSILS.**—So much has been written and rewritten concerning the tonsils that it seems almost a travesty to touch upon this subject, yet a sufficient number of cases escape the watchful eye of the general man as to warrant a few remarks upon the tonsils.

Briefly the problem of tonsillar enucleation resolves itself under one of several headings:

1. Removal of the tonsils as a therapeutic measure for hyperplasia of the cervical glands.
2. Removal of the tonsils as a therapeutic measure for frequent attacks of tonsillitis and peritonsillar abscess.
3. Removal of tonsils as a therapeutic measure for various arthritic conditions.
4. Removal of the tonsils where they are considered the source of infection in other systemic diseases, secondary to focal infection.
5. Removal of the tonsils as a therapeutic measure for chorea and nephritis.
6. Removal of the tonsils as a therapeutic measure for enlarged thyroid gland with thyrotoxicosis.
7. Removal of the tonsils on account of their size and when they become a mechanical source of trouble.

The problem of when and when not to advise removal of tonsils depends upon whether or no the tonsils are diseased.

The smallest, most insignificant tonsil, if it contains pus or secretion, is a greater source of danger than the largest tonsil that is free from deposits. To determine this brings into play the use of a pillar retractor. With the head mirror so adjusted as to secure good illumination, place the pillar retractor on the anterior pillar and make pressure upon the tonsil, looking closely for the evidence of milklike fluid or cheesy deposits, since their presence proves the tonsil to be diseased.

Having determined that the tonsil is diseased and should be removed, the next question is, should the general medical man remove tonsils? This is a delicate matter and yet there is but one answer and that is "no." The tendency of those who know least about it is to treat the matter of operative work upon the tonsils lightly, and it sometimes takes a serious accident to drive the fact home that tonsillectomy is a major operation.

The author wishes to thank the Society for the privilege of presenting this paper, which was written with the hope that it would stimulate the general practitioner to familiarize himself with the use of the simpler diagnostic nose and throat instruments and with the early application of treatment.

#### BIBLIOGRAPHY.

Ballinger: Diseases of the Nose and Throat.

Skillern: Accessory Sinuses of the Nose.

Brock: Diseases of the Nose, Mouth, Throat and Larynx; Translation by Forbes-Ross.

Jones: Journal of Ophthalmology, Otology and Laryngology, April, 1920, p. 155.

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ETIOLOGY OF TRACHOMA.—Dr. F. B. Eaton, of San Francisco, in a report to the U. S. Public Health Service of his investigations in Eastern Kentucky reached the following conclusions: 1. Outside the laboratory, and excepting the causes controlling the dissemination and prevalence of trachoma, no facts were found in medical literature substantially advancing the knowledge of its etiology since 1914. 2. Climate, soil, dust and individual predisposition, are subsidiary and contributory causes of trachoma. Some climates, to an uncertain and limited extent, appear to attenuate the virulence and diminish the contagiousness and transmissibility of the disease. 3. There is no evidence that the trachoma virus has an ectogenous existence. All its known properties, and the conditions attending its dissemination and prevalence indicate that it is endogenous to the human conjunctiva, and that that is its sole habitat. 4. There is some evidence indicating the existence of a conjunctival affection in animals analogous to trachoma, but it is inconclusive; and if existent, its transmissibility to man is, according to the teaching and precedents of bacteriological pathology, improbable. 5. By far the most potent known cause of trachoma, is interhuman contagion, due to unsanitary habits and social customs.—*Amer. Jour. of Ophthal.*, June, 1920.



## EDITORIAL

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### OUR STATE SOCIETY.

TIME grows apace. Within two months of the time these remarks are read by our readers, the Homœopathic Medical Society of the State of Pennsylvania will be in session at Harrisburg, Pa. The approaching meeting is certain to prove of unusual importance, more so in fact than any of its predecessors.

Members of our Society who have not been in the habit of attending our meetings scarcely realize the thoroughness and value of our organization. Pennsylvania has been called the Keystone State. It is fitting, therefore, that our State Society should possess the best organization of any State Medical Society the country over. We say this in full appreciation of what the assertion means. Let Pennsylvania fall, and the foundation of organized homœopathy goes with it. In no State is the profession better represented in its society affiliations, and in no State are there fewer hyphenated practitioners. We have a medical journal representing the Society, and we believe that no State organization of the country has a better one. Let our readers make comparisons taking any model they please, and we believe we will be sustained in our assertion. We have within our midst a College, the Hahnemann of Philadelphia; a Class A institution, whose Alumni in professional and public life have done credit to their Alma Mater; all of whose faculty are members of the State Society; and with whose prosperity the State Society is inseparably associated. In Pennsylvania, therefore, we have every reason for self-congratulation. But we must keep moving onward, and do still better.

We started out by reminding our readers of the important matters to be considered at Harrisburg. The first of these will be the position which we shall assume concerning the Compulsory Health Insurance Bill which will be considered at the coming session of our State Legislature. This bill is pernicious, and if passed will deprive all general medical practitioners of a decent living; and this in turn, indicates

that no self-respecting ambitious young man will assume the responsibilities of a medical career. It means that the present doctors will become the employees of insurance companies at ridiculously low fees fixed by said corporations, so low, indeed, as scarcely to pay for shoe leather and gasoline at 1912 prices. This bill is rendered dangerous by reason of the highly respectable idealists who are backing it. When analyzed, its fallacies are readily exposed. Apparently, it seems to be a good thing for the working men; really, it is good for new sets of State government employees to be installed at Harrisburg; and it is the death of the medical profession. We are acting in the matter through the State Legislative Conference with representatives of the Medical Society of the State of Pennsylvania and the Pennsylvania Eclectic Medical Society.

Practically the same bill has twice been defeated in New York State. The first time it came up, it fell by a majority of one or two votes. Last winter the profession of New York put it to a ignominious death. Let us get ready for its funeral in Pennsylvania at our Harrisburg meeting!

A second important matter for consideration is the matter of federation with the American Institute of Homœopathy. With practically every other State Society of our school already affiliated, Pennsylvania cannot afford to remain out; we must go in. But how, is the question which must be decided by us, and it must be decided wisely to the mutual advantage of the Institute and our State Society. We are strong believers in the value of organization. We believe that there should be a strong working agreement that will strengthen National, State and County Societies. No one can possibly contradict the accuracy of this statement. Again, we come to a question of details. Now we believe most firmly that in such an organization of interests no one of the participants therein should be made to appear in either the guise of a suppliant or of an almsgiver. ALL COMPONENT ELEMENTS MUST BE OF EQUAL IMPORTANCE AND BY THE THOROUGHNESS OF THEIR WORK STRENGTHEN THE PROPOSED FEDERATION. Federation there must be if we are to live as an organized body, but it will not live if its entire motto is "Give me a dollar; we need the money." It cannot live long on a sordid basis. We must confess ourselves as yet not clear on the principles or laws upon which a federation should be worked. We feel strongly

that while each and every man should work his hardest for the Society in which he finds the most congenial atmosphere, nevertheless he must recognize the fundamental principle that physicians should affiliate in turn with the County, State and National Societies, in no case being admitted to the State Society without membership in the County Society; nor in the Institute without membership in the State. We are, furthermore, clear in our mind that it is the bounden duty of both County and State Societies to propagandize membership in the Institute in season and out of season. A campaign of this character is worth far more to the parent organization than the presentation of money. It helps to make the Institute productive.

The Pennsylvania Society has a large balance in its treasury. It never had a larger. And yet we are poor, because the demands upon us are great. An analysis of our budget proves most conclusively that we cannot pay a dollar per annum per member without raising our dues; and every one knows that our dues cannot be increased beyond their present point. Personally, we believe that there is no reason whatever for paying the dollar per year per member in good standing, if we start a campaign which will bring into Institute membership every one of the over 800 members of the Homœopathic Medical Society of the State of Pennsylvania. That means \$4,000 to the Institute; "the dollar plan" will contribute but \$800.00 at the outside.

We will not add to the above any further opinions we may have, but will remain satisfied with promulgation of the principle of Federation with a Campaign for Complete Society Affiliation in National, State and County Organization. Let us join the Federation and help organize it on a life giving basis. Let us have nothing indefinite in our action; but let us be the Keystone State of the Federation, let us be the strength of the Arch.

There are other matters to be considered concerning the coming session, but as these editorial remarks have assumed unwonted length, we will defer their consideration until next month. In the interim, we would have our readers bear in mind: 1st, that there are about 250 homœopathic physicians in Pennsylvania not members of our State Society; and, 2nd, That there is a respectable number of members who are not paid up in their dues. Let each reader of these remarks make



it a point to hunt for new members; and let each delinquent pay up.

Also let us remind our members of the importance of the scientific proceedings, and of the necessity of diligent work on the part of essayists that they may present their product in a finished state at the meeting; and what is of paramount importance, that arrangement be made for debate of papers presented. The programme is a good one. Let every member take three days from practice of medicine, September 21st, 22nd and 23rd.

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#### OLD AND NEGLECTED REMEDIES.—IV. KALI BICHROMICUM.

KALI bichromicum is certainly an old remedy. We feel, however, that it is not prescribed as frequently as its value justifies. Practically its entire therapeutic sphere depends upon its action upon disorders of the mucous membrane of the respiratory tract. We have always felt that too much attention has been paid to its remarkable characteristic, "stringy or glutinous discharges," without which physicians have not seen fit to prescribe it. The matter of a "stringy" discharge is largely one of opinion. In practically all cases of pneumonic fever and in asthma, the expectoration presents a glutinous character. In very few other clinical conditions do we find this symptom present. In the pneumonias, kali bichromicum is seldom indicated unless we except the bronchial type. In the catarrhs of the upper air passages, we find it useful even though said characteristic discharge is not present. Although recommended for acute stages, it is much more adapted to the subacute and chronic phases of rhinitis and post-nasal catarrh, being indicated by the activity of the secretions of the muciparous glands. When follicular tonsillitis is associated with a great production of mucus, kali bichromicum is much more useful than the more commonly prescribed red iodide of mercury or belladonna.

It is a mistake to regard the remedy as the paramount prescription in cases of diphtheria attacking either the pharynx or the larynx. The first consideration is the administration of diphtheria antitoxin in efficient dosage. That attended to, kali bichromicum becomes a valuable adjuvant.

In catarrhal laryngitis, whether in childhood or in adult life, following the disappearance of the stage at which aconite and belladonna are the most useful remedies, there is no remedy of greater value. It is indicated then by the character of the cough, which presents a peculiar brassy sound. Usually there is associated some redness or inflammation of the fauces.

In asthma, it has served us well, not as a palliative, but as a remedy to bring more or less marked permanent relief.

We believe that the best results are obtained by the use of the first or second decimal triturations. Of the former, we advise the solution of two grains in 6 ounces of water, and the administration of two drachms every one or two hours. In certain sensitive patients, this dosage may produce vomiting, which however, never amounts to more than an inconvenience. It subsides promptly on lessening the dose. The second decimal we advise in the form of properly prepared tablets, one to be given every two hours for ambulant patients.

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#### NATIONAL CLINIC DAY, OCTOBER 19, 1920.

ALREADY the enthusiasm engendered by the proposal of a date set apart as National Clinic Day in the Homœopathic Hospitals of the United States is creating an interest everywhere. As we have stated in a previous issue, the idea is a brilliant one in the extreme, and gives every indication of being a pronounced success. Some of the hospitals have already selected their personnel of clinicians, and others are giving the matter serious attention. None are so small or so poor as to be unable to do their mite. Every staff doctor is fully alive to the responsibility that rests upon him. Although routine subjects may be presented, subjects indeed which have been "done to death" in periodical literature, in the guise of clinics, in presentation of the practical as opposed to the didactic or theoretic, they will assume a new dress which makes them scarcely recognizable as the old body.

A clinic is not a mere routine talk. It is well recognized that it is made up of a careful analysis of clinical facts, so presented as to instruct. The old idea that such a talk must be given extempore, or without careful preparation, is not to be

countenanced. Indeed the experienced clinical teacher has long since admitted that his best work in his particular field can be accomplished only by detailed study and analysis of his cases prior to his lecture. And the older one grows, the more is this fact impressed upon him. Adenoids and diseased tonsils are scarcely interesting subjects excepting to the specialists; but when cases are studied in detail, and the reasons for such operations in the individual example are properly presented, this subject takes on renewed interest. In other words it is not the operation *per se* in which we are interested, but in the analysis of the case; in the presentation of a clinical study, we wish to know the why and when; the how is for the specialist mainly.

It has been very properly suggested that these clinics shall embrace all specialties in which we are interested. This is very proper, for while it is alright to say "Give us *materia medica*" it is equally important to remember that *materia medica* is not everything, and we must remove from our school the unjust criticism foisted upon us, that we are not experts in surgery and the specialities; that we are not practitioners of one idea.

Furthermore, we believe that National Clinic Day shall be made a matter of permanent record by the publication of a suitable volume embodying the best of the clinical talks presented. For many years there has been a strongly expressed wish on the part of our practitioners that we should publish "Clinical Lectures." The best evidence of the value of such publication is found in the popularity of the clinics of "North America," "Surgical Clinics," etc., by successful old school publishers. We should make a special effort to improve on these by careful editorial supervision, which shall eliminate from the lecture colloquialisms in language, which, however forceful they may appear to be in the clinic hall, are unpleasant to the lover of good rhetoric. Previous publications by the dominant school have furthermore been open to the objections that teachers have been selected by geographic or institutional influence, and not always with the desire to present the best attainable. As homœopaths are anxious to demonstrate our capabilities, our first desideratum must be the selection of material according to intrinsic merit. A volume prepared on such a foundation will have a ready sale, and if properly



managed from a business standpoint, will make a profit which can be utilized by the Institute for its necessary work.

We need not fear that strict editorial censorship of the contents of the volume will lead to the discarding of much of the material. On the contrary, it being known in advance that nothing but meritorious articles can be accepted, will stimulate to increased endeavor. In other words, mankind generally appreciates best that for which he must do the hardest work.

In the organization of the National Clinics, the central organization is well aware of the fact that environment or facilities play an important part as to the character of objects selected for study. Were many men of many minds and kinds forced to follow the dicta of a committee of clinical popes, one can well see how direful may be the results. Our central committee is keeping this fact well in mind. It designs to serve the instructed according to indications.

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THE RADICAL CURE OF GONORRHEAL IRITIS.—Dr. S. H. Browning, of London, England, states that gonorrheal iritis, being a late sequel of gonorrhea, was not usually seen first by venereal disease specialists, and was often not treated as a urethral affection, but that if so treated, by co-operation of the oculist and the urologist, such cases would be permanently and quickly cured. Very few, if any, cases of gonorrheal iritis ought to occur, and certainly there should not be recurrent cases if proper treatment were carried out. Gonorrheal iritis is a toxic condition, not due to the actual presence in the eye of the gonococcus. In these cases there is usually a history of gonorrhea some years previously; rarely, if ever, is there a case of iritis during the acute stage of urethritis, this having been confirmed by the observation of many thousands of cases. There is in many of these cases a specific reaction to gonorrheal vaccines. It is not invariably associated with gonorrheal rheumatism. There is a recurrence of the iritis, or an exacerbation of the symptoms sometimes after prostatic or vesicular massage, probably on account of toxins being thereby liberated into the blood stream. The diagnosis is also helped by eliminating such sources of infection as pyorrhea, septic tonsils, sinus disease, and alimentary affections. Treatment was considered under two heads: preventive and radical. The first of these rested with those who saw such cases early. Great stress was laid on the need for thoroughness at the hands of a genito-urinary specialist, for in that case there should be no such condition as gonorrheal iritis. Although vaccines did not materially shorten the acute stage of the disease, the author feels that complications and sequelæ were largely prevented by their use. The radical treatment should consist of the local treatment by the oculist, with free sweats in addition, and the use of vaccines, and whatever urological treatment is indicated, whether prostatic or vesicular massage or urethral treatment. Some of the loss of repute of vaccine therapy, he thinks is attributable to the haphazard use of commercial vaccines. Vaccine treatment, however, can be no more than an aid to medical and surgical treatment; it cannot be a substitute.—*Amer. Jour. of Ophthal.*, June, 1920.

## GLEANINGS

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### MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

THE ETIOLOGY OF CHRONIC GASTRIC ACHYLIA.—K. Faber (*Ugeskrift for Læger*, Apr. 1st, 1920) gives a critical review of the literature of gastric achylia since 1892, when Einhorn first introduced this term. The author shows that the claims of conflicting theories as to the origin of gastric achylia must still be regarded as unsettled. He believes, however, that in the overwhelming majority of cases the disease can be adequately accounted for by various toxic and catarrhal conditions of the stomach itself, but there are a certain number of cases in which it is at present impossible to correlate the achylia with any definite local disease of the stomach. As in the case of nephritis of unknown origin, it is probable that further research will reveal hitherto unknown exogenous causes. The author admits that congenital constitutional anomalies may possibly play a part, but he argues that in the past these endogenous factors have been accepted without sufficiently critical scrutiny.—*British Medical Journal*, May 29, 1920.

EXPERIMENTAL HAEMORRHAGIC PANCREATITIS.—Binet and Brocq (*C. R. Soc. Biologie*, March 20, 1920) following up the previous experiments of Brocq and Morel, in which acute or subacute hæmorrhagic pancreatitis was produced by the injection of bile into the canal of Wirsung, have been able to obtain the same lesion in animals by the injection into the duct of intestinal juice obtained from a fistula of the small intestine in a human subject. The clear, transparent fluid from this fistula was viscous and alkaline, was free from formed elements and was proved to contain enterokinase. Its injection into the pancreatic duct of a dog produced a typical hæmorrhagic pancreatitis with fat necrosis. Evidently the enterokinase activated the trypsinogen in situ. Similar phenomena were brought about by the injection of calcium chloride, which also activates the trypsinogen, whilst no such results were obtained with physiological saline or with sodium fluoride, the latter of which inactivates the pancreatic reactions.—*British Medical Journal*, May 29, 1920.

ANTISCORBUTIC ORANGE-JUICE POWDER.—We have more than once pointed out how convenient it would be if the vegetable and fruit juices containing antiscorbutic substances could be reduced to a powdered form, without impairing their activity. In our issue of May 22nd, Surgeon Captain P. W. Bassett-Smith described an investigation, recently carried out at Greenwich, into the antiscorbutic potency of lozenges made from lemon juice concentrated in vacuo without heat. In guinea pig experiments their potency was very high. According to a paper on "The Antiscorbutic Properties of Concentrated Fruit Juices," by Arthur Harden and Robert Robinson, published in the April number of the *Biochemical Journal*, the drying of fruit juice has been successfully carried still further. The technical procedure has followed the lines of milk-powder production by the spray process, which avoids a temperature likely to reduce, if not to kill, the potency of the antiscorbutic agent. From the results obtained it is reported that a highly active dried orange juice can readily be prepared on a commercial scale which will

keep after prolonged storage under suitable conditions. The orange juice mixed with corn syrup was forced as a fine spray into a chamber where it met with a current of air heated to 75—80 C. The drying was almost instantaneous and the product when tested on a guinea pig was found to afford complete protection from scurvy. As the authors point out, the peculiar value of such a substance lies in its adaptability for infant feeding and for the use of expeditions of long duration, where fresh fruit and vegetables are unobtainable and when transport must be reduced to a minimum. It would appear that the orange juice is decidedly superior to vegetable juices in regard to keeping its activity when exposed to relatively high temperatures. In spite of this observation the investigation of the effects of storage on dried orange juice at tropical temperatures remains to be determined. We have already drawn attention to the fact that in the preparation on the large scale of citric acid from lemon juice by separating the acid in the form of precipitated calcium citrate the antiscorbutic material escapes unimpaired in the filtrate. Surely, it is worth while to deal with this filtrate by the method suggested herein, and so to conserve a valuable accessory food factor.—*The Lancet*, May 29, 1920.

THE UPPER AIR PASSAGES AS AN ENVIRONMENT FOR BACTERIAL GROWTH.—Bloomfield has made additional experiments covering the above question, and offers the following conclusions: 1. The free surfaces of the normal, intact mucous membranes of the upper air passages offer an unfavorable environment for the growth and colonization of certain organisms, both of the pathogenic and non-pathogenic groups. 2. Experimental inoculation indicates that these surfaces when intact are impervious to invasion by organisms which under other conditions may produce disease. 3. Various bacteria inoculated upon these surfaces in large amounts are promptly disposed of mainly by mechanical means. 4. The question is raised if some preliminary "injury" is not essential to the initiation of diseases, which clinically appear to be primary, such as pneumonia, meningitis, tuberculosis and others.—*American Journal of Tuberculosis*, June, 1920.

EXPERIENCE WITH THE SUBCUTANEOUS TUBERCULIN TEST.—Lawrason Brown and Fred. H. Heise after 24 years of experience with this test present the following conclusions: 1. These are based upon the study of 324 cases subjected to the subcutaneous tuberculin test during a period of 24 years. 2. Added knowledge has restricted this test to patients without a definite X-ray pulmonary lesion, or in rare instances to those with an apparently healed parenchymatous pulmonary lesion slight in extent. 3. Forty-two patients failed to react to a second dose of 0.01 c.c., O. T. (usually spoken of as 10 mg.). 4. Patients who fail to react to this dose may be safely returned home and to work. 5. The use of the subcutaneous tuberculin test has produced no untoward lasting result, and given as advised, has only a very temporary effect upon the patient, which however, is more usually favorable. 6. In only 2 instances did tubercle bacilli occur in the sputum for the first time immediately after the test. 7. Over 90% of 144 patients with dry pleurisy and 90% of 10 patients with wet pleurisy, reacted positively to the tuberculin test. Of 41 patients studied by X-ray, only 3 showed a positive increase of shadows. 10. Of 268 patients, only 48 (18%) showed an increase of rales during the reaction, and 21 (8%) a decrease. 11. The subcutaneous tuberculin test when positive proves tuberculous infection, but when ac-



accompanied by definite clinical changes, or more surely if by increase of X-ray changes (focal reaction), indicates that the lesion is more accessible to circulatory changes and presumably less firmly cicatrized (healed).—*American Journal of Tuberculosis*, June, 1920.

**CHEST EXAMINATION IN 1300 CASES REFERRED FOR GASTRO-INTESTINAL STUDY.**—The fact that gastro-intestinal symptoms frequently have their source of origin above the diaphragm is shown by the findings in 1300 cases referred to Grover and Christie for gastro-intestinal study. A complete examination of the chest by stereoplates and fluoroscope was made in 807 of these cases; a fluoroscope examination alone in 304; no chest examination in 189. Definite pathology was demonstrated in 506 of the 1300 cases; of this number the lesion was found to be in the chest in 170 cases. Lung lesions were found in 98 cases, and of these, 84 were tuberculous. The tuberculous cases therefore comprise about 6.5% of the total number studied, or more than 7.5% of the cases in which the lungs were examined. Coincident lesions of the lung and gastro-intestinal tract were noted in only 6 instances. The gastro-intestinal symptoms were of secondary origin in practically all of this group. Most of the tuberculous cases were of a chronic, slowly progressive type, many with extensive infiltration and fibrosis, which had escaped recognition through years of semi-invalidism. Some fairly early lesions were also recognized but this was rather exceptional. It is noted that pulmonary tuberculosis was found in almost exactly the same percentage of cases as duodenal ulcer.—*American Journal of Roentgenology*, abstracted by the *American Journal of Tuberculosis*, June, 1920.

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## SURGERY

Conducted by J. D. ELLIOTT, M.D.

**OBSERVATIONS ON EMPYEMA.**—Ashhurst discusses his views upon this subject which has created so much interest during the last couple of years. He makes a strong argument for exploratory thoracotomy in properly selected cases and describes his technic in detail.

Abstracts of the fifty-two cases upon which the author based his observations are appended and his conclusions follow: 1. Cases of pleural effusion suspected of being purulent should be punctured (with hollow needle attached to air-tight syringe); and if the effusion is massive most of it should be removed by aspiration one or two days before thoracotomy is undertaken. 2. If the fluid found on puncture is serous, or sero-purulent, thoracotomy usually may be postponed until frank pus has formed, as this delay will permit the formation of firmer adhesions and thus prevent complete collapse of the lung when the empyema is opened. Cures of such sero-purulent effusions, however, have so rarely occurred without final resort to thoracotomy that attempts to cure them by injection of antiseptic fluids into the unopened pleura are usually detrimental to the patient. 3. If in the case of suspected empyema the symptoms are urgent, but pus cannot be found by puncture, exploratory thoracotomy should be undertaken in an effort to locate and drain the pus. 4. The operation of thoracotomy for empyema should provide free and dependent drainage, secured by resection of a rib, usually the ninth, tenth, or eleventh, in front of its angle. This operation may be done with perfect satisfaction to both patient and surgeon under local anesthesia, and in most

cases this is preferable to a general anesthetic. (I have used local anesthesia with satisfaction in 27 patients, including one baby sixteen months of age; and have employed it in every one of my last 20 patients, some of them requiring rather extensive intrathoracic manipulations. It is interesting and perhaps significant to note that only two patients in the entire series developed pneumonia of the opposite lung after operation, and that both these patients had taken ether.) 5. Post-operative irrigations are unnecessary, unless after several months the lung shows no tendency to expand; then the use of the Dakin's fluid may prove beneficial. In selected cases (those with small cavity) injections of bismuth paste may procure closure of the sinus. 6. If the cavity cannot be made to heal by these means, the surgeon should do a major thoracotomy, combined with decortication of the lung and dissection of the pleura, and in some cases resection of a number of ribs to permit the chest wall to collapse in part to meet the expanding lung.—*Annals of Surgery*, July, 1920.

**FATAL POST-OPERATIVE PULMONARY THROMBOSIS.**—Ochner and Schneider give a resume of the literature upon this complication of surgery and upon it have based a careful study of eight cases which occurred in the Augustana Hospital during the five years from 1915 to 1919.

They have chosen the twelve etiologic factors whose validity seems to have been established by many authorities and have tried to discover whether any of their deaths could have been avoided by more careful attempts to eliminate each of these factors. 1. Local Infection. It seems certain that even the slightest amount of local infection may cause a thrombosis in a neighboring vein which may be loosened and serve as the cause of a fatal pulmonary thrombosis when it becomes lodged in the pulmonary vein. Although there is no evidence in any one of our cases that this has actually occurred, yet it seems important to still further perfect aseptic methods of operation. Of course, hemostasis must be accomplished as a result of a normal thrombosis of the ends of the cut vessels, but it does not seem likely that such a thrombus will ever become loosened, so that it can cause death due to pulmonary thrombosis. 2. Anemia. Most of the patients showed some degree of anemia. It seems likely that it might have been possible to correct this by more careful preliminary treatment or by transfusion of whole blood. 3. Slowing of Blood Stream. It has been claimed that keeping patients for a long continued operation in the Trendelenburg position would interfere with the blood stream in the extremities to such an extent that this serves as a predisposing cause. In none of our cases, except one, could this have been the cause, as none of the other operations were of long duration. 4. Subnormal General Physical Condition. This obtained in 3 cases, but aside from the possible improvement which could have been secured by the preliminary transfusion of whole blood, it is doubtful whether this cause could have been eliminated to a marked extent. 5. Cachexia. The only treatment which could be of any benefit would again be the transfusion of whole blood. Two of our own cases belong to this group, and were similar cases to come under our care in the future, we should make use of prophylactic transfusion of whole blood. 6. Micro-organisms in the Blood. None of our cases belong to this group, but we believe that in several cases of this class we have obtained great benefit by the transfusion of whole blood, although it is, of course, impossible to state that thrombosis has been prevented in any given case, although it failed to appear in any of these following transfusions.

7. Excess of White Blood-cells. This cause did not exist in any of our cases. 8. Inefficient Hemostasis. Until very recently we had not fully appreciated the importance of this etiologic factor, and it is quite possible that some of our deaths may have been due to an error in this direction, although fortunately our method of closing the stump in hysterectomy for many years has corresponded to that upon which Zweifel lays so much stress, and it is possible that we may have escaped many deaths from pulmonary thrombosis in this class of cases without being entitled to any credit for this. 9. Traumatization of Tissues with Retractors, etc. It seems likely that we have not exercised proper care in this direction, because until recently we have made use of heavy retractors for holding open the abdominal wound. These have now been discarded, and although we cannot trace any case directly to this cause, it seems likely that our technic has been bad in this direction. 10. Injury to Veins of Extremities Due to Badly Arranged Operating Table. Zweifel and others have traced a number of their cases directly to the use of a table in which the knees are bent, so that the veins are compressed during the operation. They found a marked reduction of fatal cases upon abandoning this particular table. We have never used this type of table, but it seems proper to again direct attention to this apparent cause. 11. Injury to Intima of Veins. Rough handling of tissues in the vicinity of the wound undoubtedly often causes an injury to the intima of veins, and it seems worth while to train one's self and one's assistant to avoid this as well as all other forms of unnecessary traumatization of tissues. 12. Excess of Calcium Salts in the Blood. So many authors mention this as an etiologic factor that it may be important to consider it. So far we have paid no attention to this element.

It seems likely from our observations that in the future we will be justified in systematically adding the transfusion of 600 c. c. of whole blood to our preliminary treatment in a considerable portion of cases belonging to a class which has in the past made up our list of deaths from pulmonary thrombosis and that the other precautions will be carried out with greater care.

It is likely that this will result in a considerable reduction in the death rate from post-operative pulmonary thrombosis.—*Annals of Surgery*, July, 1920.

**MESENTERIC THROMBOSIS.**—Ross reports the clinical, operative or autopsy findings in four cases of thrombosis of the mesenteric vessels, and the clinical course of one patient who recovered without operation. His summary is: 1. Arterial mesenteric thrombosis is a lesion causing a form of acute intestinal obstruction, rare, but occurring with sufficient frequency to make it imperative to remember its possible occurrence. 2. Its symptom complex is that of an acute intestinal obstruction, slower in onset than the purely mechanical forms of acute obstructive ileus (adhesions, volvulus, etc.). 3. Venous mesenteric thrombosis is a condition of vaguer symptomatology and slower course than that formed in arterial obstruction. It tends more to spontaneous cure, and is more likely to be a secondary or post-operative condition. When, however, its remedy by the establishment of collateral circulation does not occur, it gives the same final symptoms as does the arterial form of obstruction. 4. The treatment of mesenteric thrombosis is the treatment of any form of acute intestinal obstruction—early operation. The procedure employed must vary with the condition found at operation. (a) If the vitality of a segment of gut has been gravely affected, resection is indicated. (b) If the patient's condition contraindicates resection, the



gut should be drawn out of the abdomen, fastened to the edges of the wound and a Paul's tube introduced, resection to be performed later. (c) In the one case of this series that recovered nothing was done to the intestine and spontaneous cure resulted. While it is true that this may at times occur, and the judgment of the operator may indicate such a course, such isolated instances do not refute the general rule of early, radical procedure.—*Annals of Surgery*, July, 1920.

## DERMATOLOGY

Conducted by RALPH BERNSTEIN, M.D., F.A.C.P.

**SCLEREMA OF AN ADULT.**—Drs. Darier, Ferrand and Mircouche, under the term "scleremie," report a case of generalized scleroderma involving almost the entire skin of the patient. The skin was so hard that it was impossible to produce either superficial papillary folds or deep folds. The condition passed through two stages of evolution—first the hard edematous infiltration and then the subsequent atrophy. Along the left arm an almost invisible but definite and typically waxy line representing the scleroderma of the band-like variety was to be seen. There was no cutaneous pigmentation. The sclero-edematous areas had the usual violaceous color, and the sclero-atrophic areas had the typical appearance of old wax. About the folds of the elbows and axillæ were verrucous points and hyperkeratotic points. Histologically, there was a condensation and sclerosis in the papillary body accompanied by a perivascular edema in the corion. There was indication of an extensive connective tissue proliferation and an absence of any indication of connective tissue inflammation or degeneration which has been observed in the plaques of morphea.—*Bull. Soc. franc. de dermat. et de syph.*

**AN UNUSUAL CASE OF PSOROSPERMOSIS.**—Fernet and Scheikevitch report a case of psorospermiosis in a man 62 years old which began with a vesicular eruption closely resembling weeping eczema. Brownish, adherent crusts characteristic of the disease made their appearance after the vesicular lesions had been present for some little time. The development of psorospermiosis in a vesicular eczema associated with weeping and pruritis is quite unusual. As a rule, the disease comes on between the eighth and sixteenth years, but in this case it appeared at the age of 60 years. On the hands of the patient were congenital verrucous lesions which were probably verrucous nevi.—*Bull. soc. franc. de dermat. et de syph.*

**PUSTULAR DERMATITIS HERPETIFORMIS.**—Milan studied the case of a soldier 32 years old who came under his observation after a diagnosis of eczema had been made. On the trunk were miliary pustules, crusts and macules, which were grouped in such a way that a syphilide was immediately thought of. After a Bordet-Wassermann test had been found to be positive, without further study the patient was given a series of intravenous injections of arsphenamin. In spite of four injections, however, there was no change in the eruption. After the failure of the therapeutic test the patient was carefully studied and it was found that the lesions had been coming in a series of crops. The attack which the patient was then in had been present for two months, and he had had several attacks in the preceding three years. The elementary lesion was a pustule from the beginning. The author was able to watch these develop on the surface of the purpuric skin, which was

the site of former crops. At no time was there a vesicle or bulla present. The lesions came on in crops of from ten to twenty on the trunk and on the arms without any marked subjective symptom or sensation. They were associated, however, with slight elevation of the temperature during the onset. The pustules were about the size of the head of a pin and were never umbilicated. They never developed upon normal skin, but always upon purpuric spots. Interspersed with these bullous lesions were psoriasiform lesions, more or less copper-colored, which represented the terminal stage of the pustular groups. The contents of the pustules showed many polynuclear leukocytes, a few mononuclear leukocytes and epidermal cells. There were no eosinophiles present, but there was an eosinophilia of 4 per cent. in the blood.

The author bases his diagnosis of dermatitis herpetiformis upon the following facts: The pustules appeared in successive groups; the evolution of the lesions showed the same progressive desiccation, with the same purpuric relics; the distribution was similar to that of dermatitis herpetiformis, being localized in the folds of the skin and recurring in the same areas; there was an eosinophilia of 4 per cent., and there was an infiltration of eosinophiles in the sections studied. The pustule was found to be situated between the corneous layer and the mucous layer of the epidermis, as it is in dermatitis herpetiformis.—*Ann. de dermat. et de syph.*

**PAPILLOMATA OF THE BUCCAL MUCOSA.**—In examining a young Arab for a primary lesion of the penis, Levy-Bing and Gerbay incidentally discovered in the mucous membrane of the right cheek a group of papillomata about 3 cm. in length, extending along the interdental line. Some of these lesions were hemispherical and sessile, while others were much more voluminous, pedunculated and with mammillated summits. At the periphery of this principal mass were numerous lesions varying in size from a scarcely visible elevation to a lesion the size of a pinhead. The color of the mucous membrane in this region was normal. The consistency was firm and supple and to the touch suggested the feeling of genital vegetations. The lesions had been present for about six months and had given the patient no concern, aside from the fact that in mastication they occasionally were bitten, and unusually hard food, like crusts of bread, irritated them.—*Ann. des mal. ven.*

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## OTOLOGY, RHINOLOGY AND LARYNGOLOGY

Conducted by J. V. F. CLAY, M.D.

**TREATMENT OF MALIGNANT TUMORS OF THE ANTRUM.**—New, of the Mayo Clinic, states that the use of cautery and radium have accomplished the elimination of an operative mortality and a marked decrease in the percentage of recurrences. The number of cures by this method cannot yet be stated, but the present results are most encouraging.

The use of heat in the form of the soldering iron, followed by the application of radium, have been used in the Mayo Clinic for three years. Eighteen cases of tumor of the antrum have been treated. Sixteen of these were primary tumors and two, extensions from the upper jaw.

The diagnosis of these tumors is usually delayed until the condition becomes evident through bulging of the cheek or palate, the floor of the orbit, or the nose. Pain is an early symptom, often preceded by itching or burning. Nasal obstruction and discharge may be the first manifestations.

Often the symptoms are those of suppurative sinus disease and the antrum is irrigated until the external signs of malignancy present, when it is too late for radical treatment.

The selection of cases for this form of treatment is important. Rapidly growing lympho-sarcoma or round cell sarcoma, even though extensive, may be treated by the soldering iron heat, followed by radium. Squamous cell epitheloma of similar size would be hopeless. Involvement of the nose, sinuses or orbital floor make the prognosis grave, although help may be derived through this form of treatment. Glandular involvement is a manifestation of malignance of advanced type for the adenopathy occurs late in malignancy of the antrum.

The value of the heat is that it penetrates far beyond the point of application. The growth is attacked at a point at which it presents, either through the palate or alveolar processes. If the growth has not penetrated the walls of the antrum, an opening is made into the antrum above the alveolar border as in a Denker operation. The growth is thoroughly cooked with the soldering iron for from 30 to 45 minutes. Following this the radium is applied either at the time of the operation, or some ten days later, after some of the slough has come away. One hundred to two hundred mg for from 12 to 24 hours has been used inside of the antrum and outside of the antrum, with screening and distance. The radium may be repeated in three weeks.

Following the treatment most of the inside of the antrum comes away as a sequestrum in two months time and a large opening is left in the palate which may be closed by prosthetic appliances.—*Jour. Amer. Med. Asso.*, May 8th, 1920.

**ACUTE MIDDLE EAR INFECTIONS IN CHILDREN FROM THE STANDPOINT OF THE PEDIATRIST.**—Le Fetra states that in infants and young children, acute ear infections take rank in number and importance only second to respiratory and gastro-intestinal disturbances. He finds that the routine examination of the ears in this class of subjects will frequently reveal ear inflammation before dependable symptoms appear. Babies usually do not correctly indicate their pain. He states that tenderness in front of the ear is a valuable sign although not invariably present. A bulging ear drum is the only diagnostic sign of middle ear inflammation and only routine examination will disclose this. The drum does not always appear red. Occasionally it looks gray, due to thickened epithelium which must be mopped away to get a view of the drum. The author is inclined to conservatism in the case of bulging drums. He believes that the application of weak adrenalin to the nose and hot aural irrigations will obviate the necessity of incision in a large percentage of these cases. He feels that opening the drum makes way for infection to gain entrance from the outside. He advocates chloroform anaesthesia where incision is demanded and suggests a U or J shaped incision. He follows the incision by hot irrigation.—*Laryngoscope*, June, 1920.

**ACUTE MIDDLE EAR INFECTION IN CHILDREN FROM THE STANDPOINT OF THE OTOLOGIST.**—Saunders is impressed through his experience that an early incision in the drum is indicated in this class of cases. This procedure, properly performed, hastens a resolution of the inflammatory process and results in far less damage to the auditory apparatus. He believes that many cases of chronic catarrhal otitis media in later life, have their inception in the repeated recurrences of otitis media in childhood. A healed incision in the membrana tympani is better than a thickened muco periosteum lining



the middle ear cavity. He lays stress upon the daily inspection of cases and enjoins rest of the patient in bed until the otitis subsides. This author is disinclined to remove tonsils and adenoids during the acute stages of an acute otitis media. Later if the case tends to chronicity, such procedure may be necessary in order to clear up the condition. He emphasizes the importance of X-ray examination of the chest in cases of young children presenting evidence of middle ear and mastoid disease, in the presence of a high temperature. This should be done before deciding to operate the mastoid. He has observed many instances of the presence of chest conditions not discoverable by physical signs.—*Laryngoscope*, June, 1920.

**NERVE BLOCKING FOR NASAL SURGERY.**—Reaves anaesthetizes the nasal chamber by blocking the nasal nerve in the anterior ethmoidal foramen and injecting Meckel's Ganglion. The conjunctiva is rendered insensitive by instillation of a few drops of 4% cocaine solution. The patient looking outward, the hypodermic needle is inserted into the conjunctiva through the plica semilunaris, just below the upper lachrymal puncta; directing it inward at an angle of 30 degrees, to the os planum. At a point about 2 cm it will engage in a groove at the end of which the nasal nerve leaves the orbit. One cc of a 1% procaine solution is injected. Meckel's Ganglion is located and anaesthetized in the following way: Apply solution of cocaine to the hard palate along the roots of the molars. The hamular process of the internal pterygoid plate is located with the finger and forward a depression the palatine canal. One-eighth inch from the root of the second molar tooth a needle is passed inward at an angle of 45 degrees. The needle must penetrate from 2.75 to 3.5 cm. Here 1 to 1.5 cc of 1% procaine solution is injected. Oedema and discoloration of the eyelids has been noted as has also paralysis of the internal rectus muscle. Operations on the ethmoid, sphenoid, frontal, submucous resection, and turbinectomies, have been performed under this method of anaesthesia. The author believes the procedure better for sinus work than for septal operations.—*Journ. Amer. Med. Assoc'n.*, May 29, 1920.

#### PAEDIATRICS

Conducted by C. SIGMUND RAUE, M.D.

**FROZEN MILK.**—Dr. Harold R. Mixsell reaches the following conclusions regarding Frozen Milk: 1. There is no increase in the number of bacteria in 48 hours. 2. After 48 hours the increase is marked, although the usual lactic-acid forming organisms are not present in sufficient quantities to form a curd. 3. There is a rapid proteolysis which is pronounced at the end of 2 weeks. 4. The acidity is markedly increased, owing to bacterial action on lactose, changing it to lactic acid. 5. No marked change in the fat has been noted except that caused by bacteria. 6. It is believed by many that frozen milk, if melted and thoroughly mixed, may presumably be used with impunity, within 48 hours after freezing. 7. Owing to divergence of opinion it is better for the pediatrician to substitute a temporary formula of either dry milk or unsweetened condensed milk for milk which has been frozen, especially in feeding very young infants.—*Archives of Pediatrics*, May, 1920.

**THE TREATMENT OF CHRONIC INDIGESTION IN CHILDHOOD.**—Dr. John Lovett Morse states that digestion may be disturbed by decreased powers of digestion or increased work in digestion. Decreased powers of digestion may be due to diseases other than digestive, physical or mental overfatigue or digestive diseases. Increased work may be due to too much digestible food or to indigestible food. The treatment consists primarily in relieving diseases

other than digestive and removing causes of overfatigue. The regulation of intervals between feedings and methods of taking food is often enough to effect a cure. In the more severe cases there is intolerance for individual food elements, often with intestinal fermentation from abnormal bacterial activity. Examination of the stools reveals which food is badly borne and causes fermentation. A microscopic inspection is often sufficient to determine this but should never be depended upon alone. A microscopic examination should therefore always be made. In fat indigestion, the stools are large and semi-solid, with the odor of butyric acid, and contain a considerable amount of mucus. Microscopically fat is present, more often as fatty acids and soap. The stools of sugar indigestion are usually loose, greenish, containing acetic or lactic acid and often mucus. In starch indigestion, the stools are usually loose, brownish in color, containing acetic or lactic acid, sometimes butyric acid and occasionally mucus. Almost invariably the starch is changed partially into dextrin. In general the bacteriological examination is not of great importance in diagnosis for usually no additional information is obtained. Usually the character of the intestinal flora can be ascertained from the reaction of the stools. There is no place for the so-called digestants in the indigestion of infancy for there is probably never an insufficiency of hydrochloric acid or pepsin. The treatment consists in the regulation of the quantity of food to the capacity of the individual child. If it is necessary to cut down one food element, this should be made up by substituting another food element in a quantity sufficient to make up the required number of calories. Then the food element that causes the trouble must be given in a small quantity and increased as fast as will be allowed. The diet list must be written out explicitly and the number of calories indicated. A list of foods and their caloric values should also be given to the parents. Dr. Morse has found that almost all parents are sufficiently intelligent to use these tables. In cases in which there is marked clinical evidence of fermentation, it is difficult to say what proportion of the disturbance is due to bacteria and what proportion to chemical processes. It is probable, however, that the original difficulty is not due to bacteria. The bacteria could not be changed by giving bacteria by the mouth but only by changing the intestinal contents and this must be done by diet. The only exception to this is the gas bacillus, the growth of which might be inhibited by butyric or lactic acid. There is no place for the use of drugs in the treatment of the indigestion of childhood except for the temporary relief of symptoms. Cure can only be brought about by the regulation of life and diet. Recovery is a matter of years sometimes, but is usually certain provided treatment is kept up for a sufficiently long time.—*Jour. Amer. Med. Assoc.*, July 10, 1920.

**THE TEMPORARY TEETH: DISORDERS DUE TO THEIR NEGLECT.**—Dr. J. Roscoe Snyder declares that pediodontia is still in its infancy but merits culture and development. The care of the child's teeth is a subject that until recently was ignored by the pediatricist and neglected by the dentist. The dentist is not to blame if he gives more attention to the apparently more urgent and more lucrative demands for his services from adults. The majority of dentists have neither the time nor the inclination to treat temporary teeth. The early care of the child's teeth is a matter in which the pediatricist should assume greater responsibility. It has been estimated in New York that 98 per cent. of all teeth were perfect when they emerged from the gums but by the time the children reached the first grade in school 98 per cent. of them



had bad teeth, and one-third had abscess conditions. Equally bad conditions have been revealed by the inspection of the mouths of school children elsewhere. Much time is spent in the preparation of the food supply so that it shall be free from contamination and properly prepared, yet when it passes through a neglected mouth it may become contaminated and give rise to gastrointestinal disturbances. In the presence of an unclean mouth, infection occurs more easily. The premature loss of the deciduous teeth is the most frequent cause of malocclusion and deformities of the face and jaws. There is great need in every community of education as to the need of early dental hygiene and prophylaxis. The education of parents in this matter should not be left to the dentist but is a responsibility which the physician, and particularly the pediatrician, should assume.—*Archives of Pediatrics*, June, 1920.

ACUTE MIDDLE EAR INFECTIONS IN CHILDREN.—Dr. Limaeus La Fetra points out that in infants and children, acute ear infections take rank in number and importance only second to respiratory and gastrointestinal disturbances. Routine examination will frequently reveal an ear inflammation before the child has shown any manifestations referable to the ear by the mother or the nurse. Absence of pain or even of restlessness is no proof that the ear is not inflamed. Fever may be absent even when the drum is bulging. To sum up the indications of middle ear disease, a bulging drum is the only diagnostic sign. The author believes that by far the larger number of cases of bulging drum will subside in a day or so if the nostrils are treated by a weak solution of epinephrin, and hot irrigations of the ear are employed. "It is only when the temperature is high, the pain acute, and the bulging marked that I have deemed it best to incise at once. The infrequency of mastoid complications and the very satisfactory results of conservative treatment are my justification for awaiting further indications than those of the day of onset. If the tenderness elicited by pressure on the tragus increases, if there is tenderness of the tip of the mastoid, and if the temperature remains high after 24 hours and the bulging persists, incision is necessary." Dr. La Fetra states that in his experience, mastoid involvement has been a very infrequent complication of middle ear disease among infants.—*Jour. Amer. Med. Assoc.*, May 1, 1920.

RELATION OF ACQUIRED FOOD DISLIKES OF CHILDHOOD TO THE ILLS OF MIDDLE LIFE.—Dr. C. Hilton Rice, Jr., contributed a paper upon this subject at the 71st Annual Session of the A. M. A. He showed that a defect in nutrition might not be immediately perceptible but was nevertheless often cumulative in its effect. He makes these three points: 1. All healthy adults and children, with few exceptions, eat a variety of foods. 2. Many children left to eat what they like, turn to carbohydrates and form dislikes for essential foods, especially milk, eggs, fresh meats and green vegetables. 3. Many middle-aged sufferers from disturbances of metabolism have food dislikes that date back to childhood. These have often been anemic and constipated from childhood. After a careful exclusion of other etiological factors the conclusion seems warranted that the total or partial absence of essential foods over a long period of time may account for much disease of middle life. Some of the conditions that may be related to defective nutrition dating from childhood are hypertension, gastric and duodenal ulcer, visceroptosis, chronic Bright's disease, etc.—*Archives of Pediatrics*, June, 1920.



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## PARASITIC SKIN DISEASES IN THE AMERICAN ARMY IN THE RECENT WAR.

BY

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(Read before the New York County Homœopathic Medical Society, May 13, 1920.)

IN presenting this paper to my fellow members of the County Society I am impressed with three facts; namely, that numerous misconceptions have arisen relative to the frequency of parasitic skin diseases among our troops, both at home and abroad, that the ignorant have contributed the prevalence of these pests to our association with the Allied armies or peoples, and lastly, that acrimonious discussion has taken place concerning the efficiency or the failure of our efforts to control and stamp out the diseases in question.

It is not my purpose to describe what may be found in any textbook on skin disease concerning the numerous animal and vegetable parasites and their differential diagnoses, nor to illustrate specific treatment of the same, but rather to offer some general observations based on an unusual opportunity to observe our army both at peace and at war. At the onset let us agree upon some essentials, eliminate the unimportant factors and then proceed to the crux of the matter.

The vegetable parasites attacking the skin, such as the varieties of ringworm, favus, tinea versicolor, erythrasma and some rarer conditions, were prevalent in the army to about the same extent that they are found in civil life. Likewise, animal parasites attacking, irritating or penetrating the skin,

apart from pediculi and the *acarus scabiei*, may be eliminated from our presentation because they do not constitute a universal menace, being for the most part confined to certain sections of America and Europe. In other words, they are local, often influenced by seasonal or climatic conditions. While no one will question the torment tracable to ticks, fleas, flies, mosquitoes and bedbugs, nor deny their influence in disease transmission, it is with the so-called "itch" that we are concerned. Do not let the various terms applied to this condition confuse you. Recollect that civilians and the army do not talk the same language. The itch in times of peace means scabies just as lousiness covers the activities of three varieties of pediculi which inhabit the scalp, body and pubic region. "Cooties," a term borrowed from the military dictionary, was and is liberally interpreted to cover anything that itches, but actually embraces pediculosis plus a minority representation of scabies, thus, actually, cootie is the modern alias for louse. It has been stated that a cootie is a louse with military training.

Pediculi are not new manifestations and no matter how many millions of opportunities have been presented, they preserve their racial integrity and do not cross breed. They have existed from the earliest days of observed medicine and are found all over the globe; to be sure—under various and fanciful names. This may be expected when one realizes the intense local pride with which each country, and often the subdivisions of a country, strive to tag their products with a national label. This fondness for geographic nomenclature gives rise to much confusion in the minds of both educated and uneducated people. A pediculus is a pediculus whether of English, French, American or German nativity. Change of climate or country in no wise makes his habits of ceaseless activity, rapid reproduction of careless optimism change one iota. Nor does his physical appearance take on the colors of his native country; rather, he clings tenaciously to the white, gray, brown or black of historic memory. Just as truly all of the above refers, with characteristic differences, to scabies and the rarer parasites.

The various itches so loudly hailed in this country after the Spanish-American War as the West Indian, Cuban, Manila, Filipino or Chinese itch as well as the better defined Dhobie itch, were due when correctly diagnosed to varieties of

pediculosis, scabies and ringworm and occasionally some rarer vegetable parasite. If you will add secondary infection from scratching with resultant constitutional symptoms, or consider the elements of tropical climate, neglect and long duration, it is manifest how atypical cutaneous pictures were described and wrongly diagnosed. The same conditions could be developed here at home if some unusual factors had been present. As a matter of fact, they were and are shown at times as a native product. I saw many hundreds of epidemic cutaneous lesions during and for ten years after the Spanish-American War. These were loudly hailed as unusual but responded to time-worn and proven therapy. Most of the isolated cases were not parasitic but toxemic. I only refer to this period in our national existence because history repeats itself.

It is well to recollect that in peace times all the common parasites may be found in the United States, both in the cities and rural districts. To be sure, the relative prevalence of any of the varieties is governed by the amount of sanitary supervision exercised, or conversely, by the degree of crowding and filth plus unhygienic habits of every sort. Pediculosis capitis is so common in institutions devoted to the care of children that no mention is made in their various reports of the number of cases treated. It is not even considered a disease, but rather a nuisance. Our schools, even of the better class, are a constant source of contamination. Pediculosis corporis and scabies are to be found in every dispensary and hospital and cause no comment. Pediculosis pubes is as common among the educated and so-called upper class as among their more humble brethren. The more closely people are thrown together in various educational, institutional and social activities, as well as the longer large gatherings of men are herded for one purpose or another, just so much more are opportunities afforded the festive parasite to work his pleasure.

Any army, no matter how small, represents a collection of beings in close physical touch, hence parasites are existent at all times. Add to our small regular army an influx of millions from all walks of life and all strata of so-called society, of varying personal neatness, with many from crowded cities or unhygienic rural surroundings, and you have a parasitic ensemble hard to beat. No army has ever entirely beaten the insidious attacks of these minute enemies. It can only hope to control them at all times and, at the best, eradicate them in individual units for the time being.



While no figures are or ever will be available showing the percentage of total cases, frequency of personal involvement, susceptibility of individuals from different sections of the country to any given parasite, or the peculiar partiality that one parasite more than another shows for certain races, it is possible to make some general statements that are pertinent.

I have heard it asserted that if 10 per cent. of the recruits brought the itch to camp with them at least 20 per cent. had it before they reached the embarkation areas, and that 75 per cent. of all men serving at the front eventually acquired cooties. More tersely expressed by one authority as 20 per cent. impure at home and 20 per cent. pure abroad. These statements in themselves, while not authoritative, give a small idea of the colossal job handed to the medical service at home and abroad. In the United States pediculosis capitis and pubes were very prevalent among the colored recruits, while pediculosis corporis and scabies were more common among the whites. It is undeniable that many more cases of parasites were brought to the army than were venereal diseases. It also must be remembered how easily and rapidly these parasites multiply and spread. No brief can be offered showing a smaller number of infested cases from rural districts than from the urban population, except as refers to the ignorant foreign-born and negro recruits.

After the initial cleansing process had rid the new men who reached camp infected, reinfections were more frequently of the body variety. While some camps were more free from parasites than others, the best relative comparison could be made between individual regiments and smaller units. No doubt the amount of technical knowledge and thoroughness shown by the medical officers of the unit, together with the degree of hearty co-operation exhibited by his line commander, contributed more to the freedom enjoyed from these pests than to the amount of the original infection.

It is my purpose to show later on that some of the fundamentals of correct procedure were neglected in our army, especially in the United States. However, the medical departments of our services both here and in Europe appreciated from their own past experience, as well as from those of other nations, that parasitic skin diseases decrease the army's efficiency more than battle casualties or all of the general diseases put together. An army is efficient only as it can work

and fight. Let a large number of men be constantly detached from duty because of parasites, with the resultant skin and constitutional sequelae, loss of sleep and rest being the most important, not to mention the fact that parasites are disease carriers, then it can be understood why no one in authority will negate my assertion. All members of our medical department, whether officers or men, now realize that delousing and disinfection comprised about 50 per cent. of their total obligations here in the United States. This percentage is none too large for Europe as applied to troops before and after fighting.

It was our aim to send troops abroad free from contagion, whether of a venereal, exanthematous or skin nature. That these thousands of men boarded the transports clean is to the credit of our medical men who, it must be said, became expert because they had to not because they were originally qualified. However, I could write an essay upon the stupidity of many medical officers, especially those attached to stevedore units. The ignorance and laziness of these individuals was efficiently checked by those patient louse hunters attached to the various embarkation camps. It was the duty of these inspectors to look for everything contagious, but somehow they were fondly known as "louse hounds." Many an outfit has been held up, officers and men disciplined, individuals taken out of a command just as it was to sail, because of the acute vision, newly acquired, of the versatile inspector. Does not this last sentence alone account for delay and hence inefficiency? Our part in this war was largely summed up in the speed with which we collected, trained and shipped troops, but these same had to be free from preventable pests.

I have tried to emphasize the fact that we had parasites here in this happy land both before we had a large army and afterwards. No one who knows will deny that we always have had and always expect to. When the troops boarded the transports, which had been duly inspected and disinfected, there was always the element of human error and often the bugs came aboard or were aboard undestroyed, hence the merry war went on apace. What with frequent inspections and as frequent delousing the voyage usually ended with no greater excitement or calamity than the parasites furnished.

On arrival in England, France or Italy, the additional element of being quartered in places infected by former troops

or being billeted in infested civilian quarters added to the perplexities of the situation. The portable delousing plant, plus commendable efforts at individual cleanliness often sufficed to keep a command in training behind the lines, healthy and happy. While our laundries in France, even in the Service of Supply, did not functionate at all times, nevertheless, our efforts to wash underclothes, disinfect uniforms and reclaim damaged clothing was in a fair way to becoming a successful wholesale job by Armistice Day. All of this detail was necessary to combat the cooties.

Troops engaged actively at the front with no thought of anything but the primary purpose for which they were raised, namely, fighting, naturally acquired every parasite that neglect and filth offered. It was not to be wondered then that many of the wounded and sick, sent to the rear for treatment, were lousy. Some excuse may be offered when it is stated that the existing parasites thrived in the various hospitals and in due course infected the personnel who had never been to the front. While the active war was on, the means to disinfect were often absent, or if available, not properly and efficiently used. In some instances the medical staffs were overworked attending battle casualties and serious diseases and hence gave scant attention to parasites. Nearly three hundred thousand beds, mostly in the S. O. S., were available in the A. E. F. on November 15, 1918. If I recollect correctly over two hundred thousand of these were occupied in the same month. Hence, it may be asserted that this was no time to waste on trivialities, but sooner or later the parasites had to be killed.

Some personal testimony as to this fact may be illustrated as follows: It also offers undeniable proof that the parasites were not destroyed in most of the base hospitals, especially when they were overworked, despite the fact that specific orders existed covering this emergency. All hospital cases when they were so improved that they might be considered as possibly capable of further active duty were sent to convalescent camps, of which there were ten in France. By this means I received in my command nearly thirteen thousand officers and men, a respectable minority of whom were lousy. As it was a routine measure to disinfect every new man and his clothes, it was necessary to run a delousing plant continuously in two shifts of twelve hours each. Even with this precaution, it was evident that the work was not always well done



for the bi-monthly physical inspection revealed interesting statistics. My command averaged about forty-five hundred men and from eight consolidated reports, dating from October to January, it may be gathered that seven hundred and fifty-two cases of pediculosis corporis, thirty-two of pediculosis pubes, twenty-eight of scabies and none of pediculosis capitis were found. The unfortunate culprits were marched straight from the field to the delouser. No one could be ultimately discharged from the camp who was not free from all contagion.

After the armistice, much was accomplished in anti-parasitic directions with notable results as regards the improvement of the morale and health of all troops. Whether the men were treated near the front, as happened to those entering Germany, or in hospitals or camps in the rear, or eventually in base ports before sailing for home, the job had to be done and thoroughly.

Most of the troops before sailing for home were billeted for weeks or even months in or about concentration camps or in native villages, usually near base ports. One can hardly imagine the amount of work necessary to keep these troops clean. Their principal advantage, as compared with the experience at the front, was largely comprised in the element of time, of which there was plenty. Naturally the methods employed were sometimes crude, but the happy faculty that most armies possess—that of improvisation—came to the rescue. If the cootie can be fought near the trenches he surely could be, and was, while the men were marking time near the base ports.

The real job of delousing and disinfecting was done at such places as Brest, St. Nazaire and Bordeaux, where the plants for making one and one's uniform and possessions clean were extensive, thoroughly modern and efficient. This may be explained by the fact that the system had improved, that competent officers were selected, even some dermatologists, to supervise the work, and lastly, that everyone was so anxious to get home that wholesale co-operation on the part of officers and men was easily obtained. It was not unusual for hundreds of men to pass through the delousers in one day. These plants frequently worked eighteen and twenty-four hours daily. One who has seen long lines of men, minus everything but the shoes on their feet and the kit bag in their hand, go

through the wash room, be inspected and examined by about ten different medical men in various special lines and then emerge with clean underclothes and disinfected uniforms can appreciate what real delousing means. It covers much more than getting rid of parasites. Of course, the unlucky ones had shavings to enjoy, ointments to use and occasionally the nearest hospital claimed them until they were cured. Officers were subjected to the same thorough examination as were the men, for cooties and other ailments are no respecters of rank.

I spent five weeks in a consultant capacity at Bordeaux on my way home. It was my daily habit to visit the splendidly managed delouser and to confer with the executive, who was a real dermatologist, concerning the diagnosis of suspicious skin conditions. Naturally some commands came up for examination very free from parasites; others had so many wheals that vermin of the domestic sort or irritating straw might be suspected, while others had enough lice of one kind or another to wonder if they had ever been free. Needless to say, those in the last mentioned category had some explaining to do, inasmuch as they had some weeks in which to prepare for the final looking over. Among the fifty thousand men who passed through the delouser during my stay, there were many interesting lesions presenting practically all the common and some of the rare dermatoses. If the cases were non-contagious they were not molested or treated, for army therapy comprises the essentials necessary to make a man fight, not those demanded in civil life for beauty and comfort.

Without hesitation I can assert that our boys came home as free from parasites as they went over. No matter how many varieties they may have acquired abroad, regardless of how many times they may have been afflicted, no matter how much they knew about unsanitary homes, villages or towns, not to mention people, they were deloused good and proper and boarded transports which were equally clean. On the way home, inspections were frequent, a replica of the trip in the other direction some months before. I well remember five such performances during the twelve days spent on a navy transport. Among the two thousand men aboard, one-third of whom were sick or wounded, twenty suspicious cases were found, although in reality only six were parasitic.

Upon reaching an American port, a procedure like the one enacted at the French base port was staged only to be

reinforced by frequent inspections at the camps to which the troops were sent before discharge. Naturally, if any treatment was needed the infected ones, who by this time were few and far between, received adequate attention. Ultimately, this mass of men returned back to civil life cleaner, from a parasitic and venereal standpoint, than they were when they entered the army.

It may be said that no matter what criticism may be made of the procedures employed or the calibre of brains used in their performance, our boys when discharged were as near 100 per cent. free of pediculosis and scabies as can be hoped for in this world. Just what this means you may adduce when I say that it is impossible to state how many times individual men were deloused, either because they voluntarily sought the treatment, were ordered to take it as the result of inspections, or went through the process as a routine measure. A number of enlisted men who kept a careful record said that twenty-five times in their army life was a moderate estimate.

The single word "unpreparedness" covers all that may be said of the sum total of our failures in the recent war. We had to do things in a hurry and the wonder of it is that we accomplished what we did. It speaks volumes for the fundamental integrity of our people, not to mention their great adaptability. The medical department of the army, never famous for its professional skill apart from very notable contributions along sanitary lines, cannot be blamed for much that civilians are apt to assign. In times of peace it has been absolutely impossible to fill the ranks of the regular medical corps with the proper material or even the necessary amount of any material. Like all branches of the service, the medical expanded almost over night and eventually found to its amazement that old fashioned methods did not work where there was something real to be done. Rapid promotion of inexperienced men does not of itself develop leaders unless they have natural talent. The manual of the medical department does not and never will cover emergencies such as arose in this war.

In all regular services, criticism is uninvited, individuality frowned upon and initiative regarded with suspicion, while all that reeks of tradition, rules, regulations and red tape is exalted. Fortunately many of those at the head of affairs, especially in the A. E. F., eventually appreciated this to a large degree. They literally turned over the professional



side of the service to the men from civil life. Unfortunately, many of these civilians were incompetent professionally, as we well know. Yet in the early days of the training of medical officers, more time was spent trying to make the candidates soldiers and teach them regulations than was given to improving their technical knowledge. My personal interest in strictly military matters does not for a moment blind me to the fact that medical men were enrolled to take care of the health of the troops, not to become manual sharks, equestrians or drill masters. If we had spent the years previous to the war in preparing instead of conversing, it would have been a splendid idea to have made every doctor first a soldier and then a physician. It cannot be done in a few weeks or months.

I really believe the medical department did better even with its handicaps than most branches of the service. However, a little more vision would have saved much labor, time and money. Regarding the subject under discussion, namely, parasitic skin diseases, I can be a bit more specific in my criticism. In the United States, lack of proper equipment in the various cantonments and incomplete disinfection explains the spread of lice and similar nuisances in the early days. Add to this poor technical skill on the part of officers, both of the regular and reserve forces, because they had not enjoyed the necessary experience, nor were they taught by competent instructors, and you have the answer. Manuals and their perusal will never take the place of clinical experience. Parasites must be hunted. They do not meet the searcher half way. Our medical officers had not seen in their whole careers such an assortment as they encountered in one day in their camp life.

In August, 1917, I was told in Washington that the army did not need dermatologists as such. The regular service did not contain a single officer competent to pose as a dermatologist. A committee of three members, representing the American Dermatological Association, gave advice concerning venereal prophylaxis and the treatment of syphilis and gonorrhea. Searching for animal parasites was a job given readily to any and everyone. The fact that it was well done, locally in many instances and generally in the end, is proof only of an intense desire to serve and natural adaptability.

In the United States, as in France, the genito-urinary department included the dermatologic, with the result that competent syphilologists and gonorrheal experts with no knowl-

edge of ordinary skin diseases were expected to supervise work which called in many cases for a real education in differential dermal diagnosis. In a few instances, men of my specialty were given a chance as consultants, as personally happened to me. As a matter of fact they should have enjoyed equal privileges and authority with any and all specialists because relatively their work was more important than any except the strictly battle and accident services.

A goodly number of American dermatologists were in the service and enough could have been enrolled to have created a genuine department and then made impossible conditions which were intolerable to scientific men. To elaborate this last thought, let me say that the easy method of considering all itching skin diseases, parasitic, was generally practiced here as in France because competent diagnosticians were not used. Even when available they were commanding detachments, acting as ward surgeons or masquerading as mess officers. The average medical man does not know that an eczema case is made worse by most anti-parasitic measures and if these are persisted in will eventually turn the patient into a hospital case no longer fit for duty. A service possessing so little skill along special lines as our army medical department should have used its specialists from civil life where they were needed exclusively, and thus prevented the many errors that occurred in diagnosis and consequent improper treatment.

To sum up, I have striven to emphasize the fact that parasitic skin diseases were common in our army as in all armies and that they assumed a position of relative importance that must not be overlooked. Further, we must not blame our Allies or their people for a single parasite inasmuch as we have the native varieties here in full force at all times, and inasmuch as our army came back as clean as it went away, if not cleaner. Lastly, the end in view, namely, to keep the army reasonably free from such pests was accomplished by our medical department despite certain unavoidable factors although there were and are many lessons to be learned from what we did not do. Experience is a hard but sure teacher but it is worth while if a nation or its citizens wish to heed it.

**INFLUENZAL BRONCHO-PNEUMONIA: ITS PROPHYLAXIS AND JUGULATION.**

BY

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MANY years ago a man, whose child had a convulsion, rang my door-bell at night by mistake under the impression that he was calling another physician, saying his quest for the other doctor was based on the fact that he was known to be "hell on fits," as he phrased it.

Pneumonia with me had always been a favorite disease, and, although I plumed myself with the belief that my results in this treatment were better than the average, yet I don't wish to convey the impression that I considered myself a paraphrase of this laconic epigram.

But, when the tidal wave of influenza and broncho-pneumonia, like a plague, swept over the world in the fall of 1918 and plunged us into the fight with this terrifying monster, I soon stood aghast at its awful toll and smug complacency gave way to consternation.

I had prepared myself for the holocaust that was devastating other countries by planning a course of treatment that I still believe to be a potential one, yet its frequent failure was, I think, the result of its late administration, after the physical signs of pneumonia had developed, instead of anticipating them.

I can't recall any series of cases that gave me so much mental distress as one defeat followed another; I am peculiarly constituted mentally in that such results haunt me at night, disturbing sleep and impairing appetite, and when I saw and appreciated the woeful situations resulting from the deaths of young people burdened with the responsibilities of a family, I dreaded being called to a new case; yet many results of the treatment adopted impressed me as having a greater than coincidental value, that it possessed unquestioned potency for good, but that its opportunity for demonstrating its curative power was defeated by the time of its administration.

On mature reflection, after the pandemic had passed, I determined that in future outbreaks of the disease remedial measures with me would have to be based upon prophylaxis,



or, if this be not possible, then jugulation at as early a time as can be attained.

My experience demonstrates, to my own satisfaction at least, that the first physician who approaches a case of epidemic influenza or pneumonia bears the same responsible relationship to the patient that the surgeon does who first dresses an open fracture—he either makes or breaks.

It is clearly his duty to determine whether there is anything connected with the case that warrants the suspicion of a possible approaching pneumonia. If so, energetic action on his part will, in all likelihood, save his patient from developing a severe attack with the chance of being overwhelmed by the only too common malignant type.

If passed upon as “only the gripe” and no care is taken to estimate the character and significance of the pulmonary symptoms the incautious physician may be startled and abashed in a short time to find his patient mortally ill. Epidemic influenza certainly possesses, in a marked degree, an embarrassing talent for deception, and the wise physician will curb any tendency to be dogmatic. We miss the frank, open, stormy commencement of our old enemy—lobar or acute primary pneumonia; that infection does not long skulk but speedily comes into the open.

One symptom that should focus attention and excite critical thought is a temperature of 103 F. and over, or the persistence of the febrile stage longer than the third day; one of the most frequent causes of high temperature aside from the pulmonary complication is para-nasal sinus infection.

Per contra, we must not be deluded by the absence of fever or its presence in a very mild type because it has been demonstrated repeatedly that a commencing inflammation, represented by roentgenographic shadows, may obtain without any demonstrable physical signs and without any significant temperature changes, during a fancied convalescence, and still be the actual commencement of this scourge—secondary pneumonia.

Another symptom that heralds the oncoming of mild types of pneumonia is very significant and obtains in some cases; it is noticed a few days before the physical signs of pneumonia develop; I refer to leucocytosis.

Unfortunately this is a laboratory test and implies some delay. Influenza being a leucopenic disease any tendency to

leucocytosis will be very significant. In the severe types of broncho-pneumonia associated with the haemolytic streptococcic infection the leucocytosis may be entirely absent, due to a paralysis, toxaemic in character, of their production. In some such severe cases a very late (pre-agonal) leucocytosis is established but in many, even to the very end, leucopenia persists.

Another unmistakable sign of the approaching pulmonary infection is the development of shadows about the hilus and other areas of the lung, in some cases three days before the physical signs can be demonstrated; these changes have been repeatedly detected and always occupy larger areas than would be indicated by the physical signs. Unfortunately this examination is possible only for hospital patients.

When crepitation is heard we, of course, know that inflammatory oedema of the lung obtains and that our patient is face to face with a grave situation. A peculiar fact in connection with these broncho-pneumonias in their incipiency is the very slight disturbance of the pulse and respiratory rates and the little modification of the pulse-respiration ratio.

The physician must not allow himself to be lulled into placid complacency by the absence of tachycardia and dyspnoea because their absence constitutes a very striking and constant feature of the early stage of influenzal broncho-pneumonia. I fear there are very few of us who can consistently cast stones at those who have been hood-winked by a deceptively tranquil commencement of this complication.

We are dealing with the arch destroyer of human life—an enemy whose lethal success is largely the result of lying in ambush, which, when put aside, will mock and confound the confiding physician and may literally engulf his patient. Common sense, good judgment and prompt action, properly interdigitated, are the attributes necessary for the physician who aims to be of most service to his patient in this contingency.

In the absence of the facilities for a blood count and a roentgenogram of the lungs which involve delay, and in the face of the otherwise impossibility of being sure of the pulmonary condition, is it not in harmony with these attributes to resort to a harmless prophylactic and jugulatory measure in all cases where the slightest reason exists to suspect that all is not right and where vacillation may be followed by calamitous results?

Especially so, when, as will be shown later, this very measure had the sanction of Hahnemann more than 130 years ago as being the outstanding remedy for epidemic influenza, shearing it of its mischievous propensities.

This line of reasoning I put into practice in our last outbreak (winter of 1919-1920) of epidemic influenza with the result of having but few cases of pneumonia develop and not losing any; they were promptly jugulated, with a single exception, and this I attribute to vacillation on my part. I did not resort to this measure until the fourth day of the attack, the pulmonary signs then being detectable. Delayed resolution was the result—a mild grade of fever persisting three months, the cough another month; although pleuritic signs were prominent at one time, yet no empyema resulted.

The colloquialism “never again” expresses my sentiments.

During the summer of 1918 a leaflet issued by the house of Lily came into my hands directing attention to the fact that camphor in the proportion of 1-10000 in culture media inhibits the growth of pneumococci. In addition, when an emulsion of pneumococci was injected intravenously in rabbits, it was found that the hypodermic injection of camphorated oil retarded death from two to five days in all so treated, and saved from death 50 per cent. of the cases so treated. Another significant statement was that in over 4,000 injections of camphorated oil giving in some cases as much as 150 grains per diem no toxic symptoms were noticed.

The circular called attention to the placing on the market of ampoules of camphor containing 36 grains in 10 c.c. of olive oil.

This riveted my attention and appealed to me because camphor is often used as a resort in cases of severe circulatory depression developing late in pneumonias, although I must say I never saw any striking results, due, no doubt, to the small doses (3 to 4 grains of camphor in an ampoul), and its late exhibition. The accepted hypodermic dosage for adults is as follows: “As soon as possible after the initial chill inject 10 c.c. of a 20 per cent. solution and repeat every eight hours, except in bilateral pneumonias and in cases of severe toxemia in which injections of 15 to 20 c.c. should be given every 6 to 8 hours. After the pulse temperature and respirations are normal the injections are made every 24 hours until the lungs begin to clear up.



"The site of the injections should be the abdominal wall or outer thigh; the injections should be made slowly and the oil deposited epifascially—that is, below the subcutaneous fatty tissue but superficial to the muscle."

One of the first questions occurring to the physician is what possible danger of fat embolism attends this procedure? After an extended use of this agent no symptoms developed that suggested fat embolism of branches of the pulmonary artery in a single instance where it was used prophylactically and if it did occur in cases of fully developed pneumonia then any symptoms of this contingency were masked by the pneumonic symptoms.

I have no doubt that our views of fat embolism of the pulmonary circulation are ripe for an iconoclastic revision in the near future. Recently experimental work with intravenous injections of oily solutions is being undertaken without the development of embolization symptoms.

It is now believed that the more prolonged and less toxic effect of drugs dissolved in olive oil and injected intravenously is the result of being carried to the lung as a *fat embolism* and there gradually giving up its medicament held in solution, in this way restraining and prolonging its action.

Lethal doses of drugs in aqueous solution, strophanthin for instance, when used in oily solution intravenously in the same dosage produce a slower and more prolonged effect without resulting mortally.

As will be seen later, more camphor oil can be used harmlessly hypodermically than by the mouth, and the paradox is explained by recent experience with intravenous injections of oily solutions of drugs.

Another question that occurs to the inquiring physician is the history of the use of camphor in the treatment of respiratory infections and here, contrary to expectation, we find a champion of large doses of camphor in the treatment of epidemic influenza to have been none other than Hahnemann himself more than 130 years ago.

In his Lesser Writings, we find that "in the epidemic of 1782 there was scarcely a third, or even a fourth of the inhabitants who were not attacked by a fever presenting all the symptoms of a catarrho-rheumatic fever, though it lasted only seven days. In general they were all affected in the same degree, though there was not danger except to debilitated subjects, to

old people, and those suffering from pulmonary tuberculosis." The following excerpt was preceded by statements of his disappointment with laxatives, diaphoretics, vegetable acids, mineral acids, venesection and opium: "Camphor, on the contrary, surpassed all the expectations that could have been formed of it; it was efficacious and I may say specific, in all stages of the disease, accompanied or not by fever, especially when it was given as early as possible and in large doses. A large number of cases recovered by its use in the space of four days, in spite of the gravity of their symptoms.

"At the commencement I was very cautious in its use, and did not give to adults above from 15 to 16 grains per diem, in almond milk; but I soon perceived that in order to produce a speedy recovery, it was necessary to give, even to weak subjects, 30 grains, and to more robust individuals 40 grains in the 24 hours. The favorable result was never long delayed; the constipation ceased; the bad, or at least the bilious taste, rapidly went off, together with the nausea and discomfort; the weight and pain in the head diminished from hour to hour; the febrile rigor was smothered in its birth; the heat diminished and in those cases where there had been no perspiration, or where it had been abundant, there occurred a general mild diaphoresis, with diminution of all the drawing tensive pains in the external parts. The strength soon returned, along with appetite and sleep; the despondency changed into strength and hope, and the patient recovered his health without a drawback.

"I am afraid that this rapid disappearance of the symptoms, the yellow or brown or black coating of the tongue, the nauseous or bitter taste, the constipation and the sickness removed often in 24 hours by the use of camphor alone, given in large doses will not please the orthodox partisans of the saburral school; Nature, to be sure, often refuses to conform to the requirements of systems; the more's the pity for the dogmatic physician who attempts to fight against her.

"When I had been summoned in time, and the disease, in spite of the gravity of the commencement, had radically disappeared at the end of four days or six at the most, there did not remain a single morbid symptom, not even lassitude."

He then gives a vivid description of the case of a severe attack, violent in the extreme, where large doses ingrarescent up to 40 grains per diem effected a brilliant cure.

He says: "I only know one case out of more than a hun-

dred where the camphor failed. A lady of rank, very hysterical, subject to hysteria from her youth, had been attacked by influenza. She had taken with good effect 20 grains of camphor in 24 hours, and I prescribed for her 15 grains more, to be taken in the space of 20 hours, against some inconveniences that remained. She immediately experienced profuse perspirations, which, in the course of 16 hours, increased to a very violent degree with intense heat, faintness and anxiety. The state of the patient was very serious, but half a grain of opium allayed the anxiety, heat and sweat, in less than an hour. I prescribed it anew in much larger doses with much success, and the cure was complete. The nature of the influenza which generally goes on to copious evacuations (and on the other hand) sometimes to excessive suppression of the evacuations, in this case resisted its own specific, probably in consequence of having undergone a modification from the hysterical condition of the patient.

"Before I had ascertained all the efficacy of camphor in this extraordinary disease, I was forced to content myself with opium and cinchona."

Again, in the prologue to the article on camphor in his *Materia Medica Pura* we find the following: "When the influenza epidemic in Siberia comes among us, as it does occasionally, when the hot stage has already commenced, camphor is of service only as a palliative certainty, but an invaluable palliative, seeing that the disease is one of short duration. It should be given in frequent and ever increasing doses—it does not shorten the duration of the disease but renders it much milder and hence conducts the disease innocuously to its termination."

What better tribute can we desire than this quaintly phrased statement, from the pen of a master medical mind, as to the efficacy of camphor?

The use of camphor in large doses hypodermically is not a very recent development for we find it recommended by Seibert of New York in 1909.

The first recommendation called for a 20 per cent. solution but more recently he advises a 30 per cent. solution. He gives 1 c.c. of camphor in sesame oil for every ten pounds of body weight. Seibert believes the results are attributable to the destruction of the pneumococci in the blood current and that small doses are ineffectual.



It is most singular that the modern pharmacologic studies give us but very little definite information about the action of camphor. Whatever testimony can be gathered as to the effect of camphor on the circulation is astonishingly unsatisfactory. Camphor is commonly regarded as a cardiac energizer, yet there is a total absence of any confirmatory laboratory evidence, and so far as any effect on the vaso-constrictor mechanism is concerned, testimony seems to favor hypotension. Bastedo says: "As a vaso-constrictor camphor ranks low."

In this connection I am reminded of a severe case of broncho-pneumonia in a young school teacher, who, as the result of a severe infection was getting 150 grains per diem, hypodermically and who had an arterial systolic tension as low as 75 m.m.; at the time I regarded the marked hypotension as the result of the infection; now I am inclined to think the extreme low tension was the result of the large doses of camphor; she made a very satisfactory recovery.

The minimum and maximum dosage by the mouth ranges from 2 to 5 grains. Bastedo says: "Any good effects of camphor on the circulation are exceedingly problematical—in normal animals the rate and force of the heart continues about the same, and the total output of the heart is either not affected at all, or is slightly increased. We do not think it should be used as a heart stimulant at all, except as a single dose in emergency; even then it is entirely unreliable." So far as the respiratory organs are concerned he says: "Systematically after large doses there is some stimulation of the respiratory centers." To my mind this is an important center to have activated during the struggle with so powerful an antagonist as pneumonia.

Almost all writers allude to some of the camphor being eliminated by the bronchial mucosa; a number of my cases referred to the camphor taste after the hyperdermic use of the drug thus corroborating the elimination of camphor by the lungs; this I regard as highly significant.

"Even as much as 50 grains (I have used 75 grains at a single dose) failed to produce any definite effects either desirable or toxic" (Bastedo). He also states that "Camphor is mildly antiseptic," which, in the light of the claims of the leaflet referred to is significant.

These statements sum up the action of camphor as recorded in the latest authorities and I am sure you will agree

with me that they are negative and decidedly disappointing, considering the highly technical development of laboratory methods. However, there are very many links in the animal chain between man at the upper end and rabbits, guinea-pigs and bull-frogs at the other; we should not lose sight of this fact.

We are not considering its toxicological effects on the central nervous system in excessive doses which are, after all, the only positively determined results—confusion of thought, vertigo, maniacal excitement, delirium followed by convulsions, collapse, coma and death.

We are confronted by this singular situation regarding the action of camphor in less than toxic doses that after these many years, and after the many attempts pharmacologically to determine its action, authorities deny their ability to give the reasons for its use in medicine.

The best that can be said of the use of camphor in respiratory diseases is that, aside from an inhibitory effect on the growth of cultures of the pneumococcus, it is entirely empirical. It seems that its action is short lived necessitating its frequent exhibition to keep up its effect.

It can hardly be controverted that camphor supports vitality in conditions of great and particularly sudden stress, and yet the evidence, as before stated, so far as the elevation of blood pressure is concerned is not only lacking but there is reason to believe that it is actually lowered in full doses. But as Dr. Wood says: "It does not do violence to one's sense of reasonableness to imagine that while arterial channels are opened by vasomotor influences, the heart itself is activated."

However, in these instances of support to the individual suffering from the stress of shock due to some injury or infection the sustaining result may be, I think, entirely dynamogenic, and not due to any measurable or demonstrable effect on striped or unstriped muscle fibre.

Hahnemann says: "The action of this substance, camphor, is very puzzling and difficult to determine even in healthy organisms, because its primary action more often rapidly alternates and becomes mixed up with the reactions of life (secondary action) than is the case with any other medicine, so that it is frequently hard to distinguish what is to be ascribed to the reaction of the body, and what to the alternating action of the camphor in its primary action," and adds this further

comment: "Camphor must have a sort of general pathological action which, however, we are unable to indicate by any general expression," and naively adds: "Nor can we even attempt to do so for fear of straying into the domain of shadows, where knowledge and observation cease, whilst imagination deceives us into accepting dreams as truth; where we, in short, abandoned by the guiding of plain experience, grope about in the dark, and with every desire to penetrate into the inner essence of things, about which little minds so presumptuously dogmatize, we gain nothing by such hyperphysical speculations but noxious error and self-deception."

This was penned more than 130 years ago and we are not more advantageously placed today giving point to a somewhat cynical definition of a physician as "one pouring drugs of which he knows little into a body of which he knows less." We, of course, know that the mortality attending the pandemic of influenza in 1918 was very high, but do we appreciate fully and vividly its extent—that the estimate of deaths due to this infection throughout the entire world during that period of twelve weeks reaches the staggering total of 6,000,000? It transcends the ability of man's mind to grasp the appalling character, extent and ramified consequences of such a debacle—man's mind is too finite. Heaven knows this is bad enough, but a worse and equally harrowing feature of this awful disease is the practical certainty that another visitation of the pandemic will be due in about a quarter of a century. We also know that practically all of these deaths were only indirectly the result of influenza—really due to the complicating broncho-pneumonia, the majority of which, no doubt, were further complicated by the haemolytic streptococcic infection.

What can we do to combat this situation? Physicians have contributed innumerable articles detailing their experiences and treatments which have been as varied almost as the number of authors. Concerning the pathology of influenzal pneumonias many extensive, complete and admirable studies of the bacteriology and histology have also been contributed, but these also have, unfortunately, not brought us one whit nearer to its intelligent control. When the treatment of the broncho-pneumonia itself is under consideration a vein of pessimism, funereal in character, seems to dominate the contributions of those entitled, by virtue of their experience and attainments, to respectful attention. "Floundering" is the best term to ap-



ply to the majority of treatments advocated by the dominant school writers, and, although our school still persists, in lieu of anything better, in prescribing our "standbys," yet, in these secondary pneumonias of the streptococcic type they are worth no more than the measures advocated by the dominant school of medicine.

It is most singular how completely helpless one feels—and not only feels, but *is*, in the presence of a broncho-pneumonia, mixed with the streptococcic infection. The perplexity of the medical world on this subject is truly deplorable. Contrawise, I am not unmindful of the articles appearing in the journals detailing the experience of physicians who claim to have treated hundreds of cases of influenza with numerous instances of pneumonic complications without a death. I certainly envy the mental satisfaction and serenity that justifiably attend such results. From this welter of reports, essays and contributions pathological, bacteriological and clinical, there can be but one deduction that comports with common sense, and that is the ruling principle of success must be based on prophylaxis or jugulation at the earliest possible moment.

Any treatment for the fully developed haemolytic streptococcic pneumonia must, at this time, be regarded as a pretense, and the sooner we admit this fact the better it will be for those who entrust their physical welfare to our care, and the better will they fare.

So far as lobar pneumonia is concerned, due to infection with one of four different types of pneumococcic, the specific serum treatment for some reason can be depended upon in the treatment of the infection due only to type 1. Cases the result of infections with the other three types have, so far, proved resistant to serum treatment; this is the experience of those in charge of laboratory work in the Rockefeller Institute. They have demonstrated a remarkable reduction in mortality in pneumonias the result of type 1 infections.

But it is vain that we at this time look for aid from this source in the treatment of the variety of pneumonias that we are considering. The principal reason is due, I think, to this fact: lobar pneumonia limits its activity to the intra-alveolar membrane, and when recovered from leaves the histological integrity of these tissues unaltered. Broncho-pneumonia, on the contrary, owing to its associated staphylococcic and streptococcic mixed infections, invades the peribronchial and inter-

alveolar tissues, stroma of the lung, and in all cases there is some organization of the inter-alveolar and peri-bronchial effusions and are never attended with a return to normal local conditions.

One characteristic feature of streptococcal infections is their spreading peculiarity, tendency to diffuseness, an unwillingness to remain localized; in trying to make plain to my patients the reason for its awful mortality, I liken the condition to an erysipelas of the lung engrafted upon a pneumonia. To the physician trained to individualize his cases when prescribing, who, in other words, treats the patient and not the disease by whatever name it is known, there is a peculiar repugnance to seek after a specific treatment. Yet, what in the whole range of medicine, can be found more satisfactory than the treatment of diphtheria with its suitable anti-toxic serum? I am sure we don't attempt to individualize when called to treat cases of diphtheria. The sooner the suitable antitoxine is used the better; no matter what else is used, it is the one thing essential.

The ideal treatment for these broncho-pneumonias, theoretically, should be based on a similar line of reasoning, and the hope will not "down" that some treatment will develop that can be looked upon as specific; the furrows cut by our harrowing failures will not always remain barren and surely "somewhere, somehow, sometime," the discovery and announcement will be made that this much coveted consummation has been attained. I say surely because I can't believe that such enormous portions of the human race can be resigned, by our Creator, to the caprice of fate and consigned to the maw of such an insatiable Moloch without supplying some remedy. However, I feel safe in making the prophecy that its exhibition for the best results will, as in the use of diphtheria antitoxine, be along the lines of prophylaxis and jugulation.

Coming practically to the subject of prophylaxis I wish to allude to a fact that must have attracted your attention—that is, the highest rate of mortality between the 20th and 35th year; older and younger people have a better prognosis. In the other varieties of pneumonia not so apt to be associated with the streptococcal infection we find these ages (20 to 35) to be attended with a far better prognosis than those of 40 years and over, those who are so apt to have the handicap of visceral degenerations which the younger adults have not developed.

"May it not" (to adopt a Wilsonianism) be the result of the greater sexual activity of adults between the 20th and 35th years? This is the surpassing difference in the habits of those in these two periods of life. There is reason to believe the greater incidence of pulmonary tuberculosis at this time of life has this greater sexual activity as one etiological factor. It may be that there is less resistance to streptococcic infections in the sexually active, and it will repay the younger element to throttle sexual tendencies when epidemic influenza is bruited abroad in the newspapers.

We have all been impressed with the value of vaccines in the prophylaxis of tetanus and typhoid infections, and, to my mind, it is perfectly logical to anticipate a similar benefit from the use of a vaccine containing the four types of pneumococcic and haemolytic streptococci. These should be used before the attack of influenza for the best result. Peiffer's bacillus at this time occupies a rather anomalous position. Years ago it was accused of being the direct infecting agent in the production of influenza and maledictions were hurled against it, but now considerable doubt is expressed by many able workers who are inclined to shear it of its responsibility as the active infecting agent, a verdict that should salve the conscience of this long execrated microbe; etiologically, epidemic influenza is still one of our Mavericks. I fear in our estimation of the value of vaccines we make the mistake of regarding a mild attack of the disease as a failure of the immunization process. When we inoculate with cow-pox, an attack of varioloid is regarded as proving the value of the vaccination in that typical small-pox did not develop. So, we must not, I think, look for absolute immunity in other vaccinations—if shorn of their power of greatest evil much has been gained.

I think all cases of epidemic influenza should be given 10 c.c. of a 20 per cent. solution of camphor in oil within the first period of 24 hours, and a similar dose morning and night during the second period of 24 hours; this will, in the words of Hahnemann "conduct the disease innocuously to its termination." In some cases it is not altogether clear as to whether the broncho-pneumonia should be regarded as a complication or an integral part of the influenza, the two infections developing coincidentally. All the more reason in this dual infection for the use of camphor; the chances for jugulation are far better. I think I have shown by ancient and



modern writers that camphor is a close approach to a specific for influenza and its associated pneumonia either singly or combined.

There should be no hesitancy in its use. I know we will tend to vacillate in the mildest cases but I find that patients are so alarmed at the possible development of pneumonia that they gladly agree to the annoyance of the hypodermic injections. In my opinion, the use of camphor is imperative if the slightest doubt exists as to the condition of the patient—the very fact that a doubt is entertained to my mind is sufficient warrant for its exhibition. In the fully developed broncho-pneumonias, with the ear-marks of severe infection, I was repeatedly gratified with results that were astonishing in promptness and thoroughness.

Those cases that seemingly are the most hopeless, in which a pneumococcemia obtains, as demonstrated by cultures from the blood, the free exhibition of camphor by its inhibitory action on the pneumococci in the blood may help to stem the tide in favor of the patient. Again, when acute vasomotor paralysis develops, as the result of the intensity of the toxæmia, the dynamogenic action of camphor in large doses frequently repeated may save life; this, at least, is better than doing nothing. This may seem too enthusiastic.

I am acquainted with the criticism of Dr. Cole, of the Rockefeller Institute, about "the waves of strychnine enthusiasm and camphor enthusiasm sweeping over all large hospitals," but I very much question that the drug was used prophylactically or in the earliest stage to jugulate the infection. To use the drug after the toxins are generated in huge amount, as is the case when such cases are admitted to hospitals, is parallel to using diphtheria antitoxin in the latter stages of that infection.

There is nothing novel about this paper, except, possibly, the advocacy of camphor as a prophylactic of pneumonia which its innocuousness makes possible, and which I desire to impress upon you. The lodgment of camphor in the lungs, which must obtain for its elimination by the bronchial mucosa must make its inhibitory action locally on the growth and development of pneumococci peculiarly advantageous to the infected individual. Why should we not be enthusiastic when we have practical acquaintance with a measure giving results above the average?

To my view, the physician who can offer nothing better than aspirin for the influenza and later nothing more nearly related as a specific than digitalis to a patient who is despairingly fighting a losing battle with this powerful antagonist, cuts a very sorry figure in the sick room because there must be subconsciously reflected in his demeanor the lack of confidence in his armamentarium.

Coleridge says: "He is the best physician who is the best inspirer of hope," and to succeed best in medicine is to possess the faculty of impressing on the mind of the patient the belief that he is going to get well. Having confidence in the power of the stone in your sling and the knowledge how to attack this Goliath, giving him no advantage as to time, gives to your deportment an aplomb that psychically can not fail to inspire the hope that "quickens all the still parts of life, and keeps the mind awake on her most remiss and indolent hours; it is a kind of vital heat in the soul that cheers and gladdens her—it makes pain easy and labor pleasant" (Addison).

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### ECTOPIC GESTATION.

BY

WILLIAM ERWIN, M.D., PHILADELPHIA.

(Read before the 23d Ward Homœopathic Medical Society of Philadelphia, December 17, 1919.)

I DESIRE to call your attention to an abnormal condition of the pregnant woman marked by very obscure symptoms, a particularly difficult one to diagnose correctly and promptly, and one that is almost sure to terminate disastrously unless met by early removal by abdominal section.

Ectopic gestation, also called ectopic pregnancy or extra-uterine pregnancy, is a comparatively rare condition. Statistics of its frequency in comparison with normal pregnancy are not available; suffice it to say that I saw my first case in the forty-third year of my practice, and what seems quite as remarkable my second case occurred less than three months after the first one.

Ectopic gestation may occur in the ovary (though Wood of Cleveland says that while this is possible it has not yet been

proved), it may occur free in the peritoneal cavity, or at the junction of the fallopian tube with the uterus, called the interstitial form, or as is nearly always the case it occurs within some portion of the fallopian tube. If occurring in the ovary impregnation occurs before the ovum leaves the ovary, where it remains, making necessary the differential diagnosis from an ovarian tumor. When found free in the peritoneal cavity the ovum fails to enter the fallopian tube, and the placenta attaches itself to some portion of the peritoneum, or, as usually happens, it results from a tubal rupture directly into the peritoneal cavity, or it may first rupture into the broad ligament and then into the peritoneal cavity.

The ovarian form is difficult to diagnose from an ovarian cyst, except that it develops more rapidly than the latter; the free abdominal variety may develop to near or quite full term or possibly somewhat beyond full term, and the fetus then perish and be carried indefinitely; or as more frequently occurs it may decompose and ulcerate and discharge piecemeal into the intestinal canal, into the vagina or bladder, or through the abdominal wall. A living child has been known to result from this variety of ectopic gestation, being delivered by abdominal section. Bi-lateral ectopic gestation has been recorded.

The interstitial and tubal varieties are sure to burst their confines because of insufficient enclosing tissue to permit of the expansion necessary for development. Such rupture, usually occurring during the second or third month, discharges into the peritoneal cavity with violent pain, dangerous shock, and hemorrhage which is liable to prove fatal. The rupture and discharge may occur into the broad ligament, in which case the symptoms of shock and hemorrhage are less severe.

Previous inflammatory conditions of the fallopian tube, generally of gonorrhoeal origin, may cause a stricture that does not entirely close the calibre of the tube but is sufficient to prevent the passage of the ovum, or a sacculated condition of the tube may form from the same cause, into which the ovum may become lodged are very plausible causes, but others can not be positively named, though it is believed that a fright, a shock, or violent emotions may possibly have a determining influence.

Morning sickness is as liable to be present as in normal pregnancy. The uterus is almost sure to be slightly enlarged,



though it does not continue to develop with the continuance of the ectopic condition, and its cervix does not develop as in normal pregnancy. The os uteri is said by text books to be patulous; in one of my cases it was so, but in the other it was not. Text books say that intra-uterine decidua are formed and discharged at intervals in shreds accompanied by an occasional "show" of menstrual blood. In one of my cases there was no "show" at all until two months after conception, when a regular but painful menstruation occurred which did not entirely cease until after operation. In my other case the occasional "show" appeared, but no shreds of decidua were found in either case. While a complete decidua vera has been found in a single piece, it more often happens that decidual shreds can be detected only by a microscopical examination of the uterine discharge.

In nearly all, probably in all cases, there is enough of colicky or crampy pain in one or other ovarian region to call attention to the presence of something that is not exactly right. This may not be enough to send the case to her medical attendant, or it may be of almost any degree of severity. In one of my cases it was obscured by a co-incident appendicitis, and was attributed to that cause; in the other case it was not present. Also upon careful bi-manual examination it is generally possible to make out an unsymmetrical enlargement in the pelvic region, with a sensitive spot at the location of the ectopic. Such examination should be made with care for fear of causing a tubal rupture. Also the possibility of a uterine fibroid should be borne in mind.

Sometimes these pelvic symptoms are so mild that the first strongly suspicious symptom is a violent pain in the uterine or ovarian region, followed quickly by severe shock and internal hemorrhage, which is likely to be so severe as to cause fainting and all signs of collapse. The physician is quickly called only to find, if he makes a correct diagnosis, that an ectopic gestation has developed and progressed to the point of rupture and dangerous hemorrhage. The hemorrhage being intra-peritoneal and, therefore, concealed, no idea can at once be formed as to whether it has ceased or whether it is still sapping the unfortunate patient's remaining vitality. At this stage the patient's safety and quite likely her life depend upon an immediate and correct diagnosis, with abdominal section as quickly as she partially rallies from the shock, which in such

cases is always severe. Such rupture generally occurs during the second or third month of gestation, and seldom occurs later than the fourth month. When the ectopic is located very close to the fimbriated extremity of the fallopian tube, a tubal abortion may occur (instead of rupture), with discharge of the fetus into the peritoneal cavity, and the same train of symptoms as are characteristic of tubal rupture.

In a suspected case of ectopic gestation it is not safe to measure the depth of the uterus with the sound for fear of producing an abortion in a normal case of pregnancy. There do not seem to be any infallible signs of ectopic gestation, and it is generally diagnosed by the detection of several suspicious conditions in combination. The apparent slenderness of the cervix uteri may be a presumptive sign, but in multiparae the usual enlargement of the os and cervix resulting from parturition greatly obscures this sign. Ectopic gestation nearly always occurs either in nulliparae or in those who have passed several years since their last confinement; this, however, is only a comparative sign; both of my cases had been pregnant before, one of them nine years before, having had a normal child at term; the other soon after marriage had an ectopic gestation sixteen months before, and an accidental abortion eight months later, followed in another eight months by a second ectopic; and previous gonorrhoea was ruled out in both cases.

Along with the usual presumptive signs of pregnancy, a "show" either singly or repeatedly at intervals of some hours or a day or two, at about half way between the first and second month, or about half way between the second and third month is considered almost conclusive evidence of an ectopic condition, and also quite as prognostic of rupture within about two weeks if let alone. My first case had no "show" whatever.

Loizeaux of New York says, "A large percentage of cases, even after rupture, do not present a majority of the striking characteristic symptoms and physical signs whereby the condition may be surely differentiated from other grave abdominal emergencies," though he might have added that after a rupture and hemorrhage a hematoma is always present in the cul-de-sac of Douglas. Loizeaux also quotes R. R. Smith who tabulated 2,998 cases, with recurrent ectopic in 3.8 per cent. Danforth of New York says that intra-uterine and extra-uterine gestation may co-exist.

While it is true that death and mummification of the fetus by partial absorption is possible at almost any stage of this condition, the delay of waiting is dangerous to the mother because of the far greater likelihood of decomposition, supuration and ulceration into neighboring structures or through the abdominal wall, but the greatest danger of all is that of rupture and a fatal hemorrhage into the peritoneal cavity. Because of these dangers, the use of electricity to kill the fetus, is mentioned only to be condemned. Medical treatment is of no avail whatever.

The only wise course is to be constantly on the alert to the possibility of this grave condition, to make the earliest possible diagnosis, and then terminate it by surgical removal. Surgical intervention is best taken before rupture, but if rupture and hemorrhage occur before the diagnosis has been made, the operation should then be done as soon as the patient has partially rallied from the shock, for fear that a second hemorrhage, which is always liable to happen, might terminate her life.

Few if any critical conditions confront the physician where there is greater need for immediate accuracy of diagnosis, and promptness of correct treatment, to save a human life from an untimely end.

My two cases of ectopic gestation may be briefly noted as follows:

Mrs. D., aged about 31, who is the mother of one child nine years of age, consulted me for what her physician called "indigestion," from which she had suffered acute attacks at intervals for about two years. From the history of the case, and the present condition I diagnosed chronic appendicitis and advised appendectomy. She had missed one menstrual period, and without any unusual symptoms or any warning, at the time for another period had she been menstruating, it came on with violent pain and the os uteri was found quite patulous. The severe pain was attributed to a fresh attack of appendicitis, but rupture of the right tube doubtless occurred then, for at operation about a half pint of blood clots and an eight weeks' old fetus were removed from the peritoneal cavity. The right tube had ruptured close to the ovary, and was removed together with the ovary and inflamed appendix. The left tube was dripping with blood at a point corresponding with the rupture of the right tube, and was, therefore, resected. She made a perfectly satisfactory recovery.



Mrs. McC., a sister of the above named lady, and slightly older, about four months after marriage and removed to Virginia, was taken suddenly and dangerously ill with some undiagnosed abdominal condition, which, upon operation by a Newport News surgeon, proved to be a ruptured ectopic gestation with a nearly fatal hemorrhage. The right tube, the right ovary and the appendix were removed. Recovery was very tedious from the great loss of blood, but eight months later she had an abortion at two months, caused by jolting in a rough automobile ride. After another eight months she had returned to this city, and consulted me for the morning sickness characteristic of early pregnancy. About six weeks after her last menstrual period she developed the "show" of blood so suspicious of the ectopic condition, but the os uteri was not patulous in the slightest degree. After careful examination I made the diagnosis of unruptured ectopic gestation, which at operation was proven correct by its removal together with two and a half inches of the remaining left tube which contained it. The ovary was saved, she quickly recovered and now menstruates normally.

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#### **A CLINICAL CONSIDERATION OF ACUTE MASTOIDITIS WITH SPECIAL REFERENCE TO INDICATIONS FOR SURGICAL INTERVENTION.**

**BY**

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(Read before the Homœopathic Medical Society of Germantown, June, 1920.)

THE general increased interest in otological conditions as evidenced by practitioners of medicine is indeed encouraging to those who are especially interested in furthering the knowledge of this subject. Acute inflammatory conditions of the ear are receiving earlier and more energetic treatment. Aural prophylaxis is being practiced through the better understanding and increased interest in nose and throat pathology. Chronic suppurative ear conditions are on the decline, due to the early attention to aural complications in measles and scarlet fever, and to the attention to adenoids and tonsils, when these ear conditions threaten chronicity. The subacute ear conditions are no longer allowed to drift along without the necessary mechanical attention. Thus all along the line we observe the generally

better care of the ears. This has a most beneficial effect upon the laity. It has been a long, hard pull to extricate the ear from the mire of obscurity and ancient mysticism in which the laity have hitherto loved to submerge most of the ailments of mankind.

The subject of acute mastoiditis was chosen for consideration this evening not because we have anything new, but because it is a subject of great importance. It bears repetition. It has an aspect in regard to life which interests every physician and it has a relation to the special senses of hearing and equilibration.

For clinical purposes, acute mastoiditis may be considered as part of, or an extension of, an acute otitis media; for in every active middle ear infection, the mucosa lining the mastoid antrum and cells become simultaneously involved by reason of the anatomical relation. In the less active infection the mastoid becomes involved by the cell route or by vascular channels. An analogy is seen in the pathology of severe rhinitis or acute cold in the head, the mucosa of the nasal sinuses taking part in the acute pathological process with the production of acute sinusitis.

While the mastoid is involved in a great majority of acute middle ear infections, not all cases go on to suppuration and require operation. The determining factors at this juncture would seem to be, the resistance of the patient, the virulence of the infection, the type of mastoid and the adequacy of and the time treatment is applied to the middle ear infection.

That the resistance of the patient has much to do with the development of mastoiditis is very clearly set forth in the records of the earlier experiences in the military training camps. Here large numbers of men were gathered where measles and acute upper respiratory infections became epidemic. The victims were strange and depressed; the mode of life was entirely new. They were called upon to perform physical feats to which their bodies were unused. They were depleted by the infection, so that the middle ear and mastoid offered little resistance to the invasion and acute suppurative middle ear and mastoid disease became a veritable epidemic. This lack of resistance is again exemplified in children who have been seized with measles or scarlet fever, the two diseases which are so notoriously complicated by otitis media. Influenza of the endemic type, is responsible for a large num-

ber of cases of acute mastoiditis. Usually, in these instances, some form of streptococcus is found. These cases exhibiting streptococci bear careful watching. The streptococci *viridans* and *haemolyticus* were observed in camp epidemics. The streptococcus *mucosus capsulatus* is particularly dangerous in that the infection apparently passes into a quiescent stage, then under slight provocation, it is awakened into renewed activity and a destructive type of mastoiditis results. This offers a dangerous and illusive type of mastoiditis, especially to the inexperienced. Clinically we have observed that mastoiditis occurs in its greatest numbers from mid-winter to early spring, and, as in all bacterial diseases, variations in the behavior are noted from year to year.

The anatomical make-up of the mastoid process plays an important role in the clinical manifestations when infection invades the part. Where the mastoid is of the infantile type, that is containing few cells, the inflammation spreads from the middle ear to the mastoid antrum and gives no further trouble; there are no cells to become involved. Here it is possible, in milder cases, to have no mastoid symptoms present. If, however, infection be of a particularly virulent character, the inner plate may be called upon to bear the brunt of the infection with consequent danger to intra-cranial structures. In the cellular type of mastoid there are many cells throughout the process. These offer a field for extension of the middle ear inflammation through the additus and there occurs many small more or less localized foci which later break down, fuse and finally form one large abscess seeking an outlet. Erosion may occur in the outer plate, when the periosteum and soft structures covering the cortex become involved with the consequent development of a collection of pus beneath the periosteum—a sub-periosteal abscess. In a goodly percentage of operated cases we find that the outer plate of the mastoid has resisted the infection and that the inner plate has given way, the absorption of which exposes the middle fossa, the sigmoid sinus or the posterior cranial fossa. Widespread absorption of the inner plate occurs at times without clinical symptoms indicating that such has taken place. Operative experience would lead us to believe that the dura in these regions is far more resistant to infection than the anterior fossa.

Once the mastoid becomes thoroughly infected with the production of pus, drainage is difficult through the antrum and



middle ear because of the smallness of the opening and this normally small passage way is narrowed by swollen mucosa and, at times, granulation or polypoid tissue. Thus the suppurative process within the mastoid is practically closed.

The cellular distribution in the mastoid is also responsible for the variation in the external manifestations. When the cells extend above and anterior to the zygoma, such cells becoming involved in a mastoiditis, would present tenderness and if the process had progressed, swelling in this locality. This is spoken of as the zygomatic type of mastoiditis. Another regional extension of mastoiditis occurs where the cells are grouped in the tip and where there are usually thin walls. Erosion of the bone occurs beneath the tendinous line of attachment of the sterno-mastoid and splenius capitis muscles. Or the erosion may occur on the inner surface of the tip. This opens a way for infection to pass along the deep fascia beneath the muscles. Such extensions may occur anterior or posterior to the sterno-mastoid muscle. In the former instance, swelling will occur below and anterior to the mastoid tip, while in the latter instance, the swelling presents below and posterior to the tip. Such submuscular extensions may extend to the clavicle below, or to the spinal column posteriorly, the limitations being occasioned by the attachment of the deep fascia. This spreading of the mastoid infection through the tip into the neck has been dignified by the name of Bezold, the clinician who made the first anatomical investigations of the condition.

Such extra mastoid wanderings of infection are positive indications for mastoid operation. Zygomatic infections endanger the middle fossa. Bezold's extensions are dangerous through general sepsis. Furthermore these extensions may and often do assume a chronic state. The process proceeds very slowly, often all the evidence of middle ear involvement having cleared up before the extra mastoid extension is noted.

All other things being equal, the earlier the middle ear is adequately drained in acute otitis media, the better chance the patient has of escaping serious mastoid involvement. There are, of course, especially virulent cases in which the mastoid has been found necrotic and filled with pus, 72 hours after the onset of symptoms, but these are very exceptional. Military medical men had ample evidence of the good results accruing from early opening of the ear drum. During the in-

fluenza epidemic, the civil population affected showed little involvement of the aural tract but in the camps, the occurrence of otitis media was frequent. In these instances, undoubtedly, the invasion of Pfeiffer's bacillus activated a streptococcus which was simply awaiting a comrade in arms. In our experience in a naval hospital where there was no overcrowding and where pneumonics were quickly isolated and where there had been no special epidemics of a streptococcic nature, the aural complications were insignificant. Cases were carefully watched for the development of aural symptoms. If a patient seemed dull of hearing or unusually drowsy, we examined the ears. Many of the patients were too sick to appreciate that their hearing was dull or that they had ear pain. In this way we discovered many cases with inflamed and bulging drums, showing the evidence of middle ear involvement.

The adequacy of the treatment of the middle ear infection is dependent upon the attending physician's ability to accurately diagnose the cause of ear pain, to differentiate the inflammatory conditions and to apply proper surgical measures. We say surgical measures because a large percentage of cases reach us too late for medicinal treatment. We can hardly credit medicine with a triumph when a patient, after suffering from 12 to 24 hours or longer, suddenly develops discharge from the ear and is made comfortable. This is a credit to nature that the process ruptured externally. They do not all do this. In some instances the drum is so thickened from previous pathology that it cannot rupture.

The initial symptoms of acute inflammatory ear pathology are usually sufficiently pronounced as to attract the attention of even the casual observer. This applies in all cases except, as before mentioned, where the ear condition complicates some virulent systemic infection, such as measles, scarlet fever or influenza. In such instances, where the patient is very ill and febrile; it is possible to have the ear condition make its appearance without pain. The attending physician, therefore, should examine the ears of all cases that are complicated by ear conditions just as he watches the heart for involvement in rheumatic and septic states, or he watches the urine for evidences of kidney involvement. This is a very important part of a complete physical examination. It, of course, entails an expenditure of time and necessitates a knowledge of practical otology, but this is within the reach of any

man who has good vision if he will but practice the use of the ear speculum.

The occurrence of otalgia is a signal of trouble and calls for a direct inspection of the drum head. The characteristics of ear pain of the middle ear disturbances will frequently suggest, to one not sufficiently expert in otoscopic observations, at least a tentative diagnosis. The pain is paroxysmal and aggravated by such acts as tend to open the Eustachian tube—coughing, blowing the nose, swallowing, etc. The occurrence of impairment of hearing or fullness or throbbing should cause ear investigation. A sudden accession of temperature or marked restlessness may be the first indication of ear complication, but temperature is not necessarily present.

Where there is a collection of fluid in the middle ear cavity, with a bulging drum, we should not wait for the drum to rupture. Incision should be practiced to afford early and efficient drainage. This constitutes the first step in warding off mastoid extension. At the time of the incision of the drum a culture should be made of the fluid in the tympanic cavity. It is our practice to take such culture from the knife used in incising the ear drum. In a very few hours we have positive evidence of the character of the infection and vaccine therapy, either autogenous or other, may be employed as an adjunct in combating the infection.

If the middle ear drainage is not sufficient and if the resistance of the patient is below par, or if the infection is overwhelming, or if anatomical impediments are present, supuration within the mastoid occurs.

The popularly expressed physical evidence of operative mastoiditis is the presence of post auricular tenderness with oedema and redness, or swelling with fluctuation. This is true, but such a case has been allowed to progress to close to the danger of cranialward invasion in waiting for the external manifestations of abscess. While the erosion of the outer plate has been taking place, there is very likely a similar destructive process going on in the inner plate. This cranialward extension may readily occur and the outer plate not present evidence of involvement. Very frequently the case that presents the large postauricular fluctuating swelling, the "over ripe" mastoiditis, does not present the same imminent danger as does the quiet case. In the former instance nature is trying to perform an external operation, has broken through



the bony external barrier and has made an outlet beneath the soft structures, or it may even rupture through the skin affording a complete drainage for the pus. On the other hand, the quiet case, lacking external evidence, the destructive process is passing inward and the first alarming evidence is signs of intracranial extension. These are the cases requiring diagnostic acumen. Good mastoid surgery means eradication of the diseased process before the bony plates become eroded. This brings us to the question: when should the mastoid be opened? The answer is, when adequate drainage cannot be accomplished through the additus, tympanic cavity and ear drum, or when, even though drainage is free, there are symptoms of extension or threatened extension through either of the bony plates.

Insufficient drainage is indicated by mastoid tenderness, discharge from the ear and changes in the drum head and canal walls.

Mastoid tenderness is a valuable symptom. It is observed as (1) early, (2) persistent, (3) late, (4) recurrent.

Early mastoid tenderness is present in severe cases of acute otitis media. Early opening of the ear drum frequently furnishes sufficient drainage with relief of this symptom in a few hours.

Persistent mastoid tenderness is a continuation of the early tenderness, that is lasting over 24 or 48 hours after drainage of the middle ear and is a reliable guide as indicating activity within the mastoid. Late mastoid tenderness comes on several days or weeks after the onset of the acute middle ear manifestations and usually indicates a progressive pathology within the mastoid.

Recurrent mastoid tenderness is observed in cases where the early tenderness is relieved but in the course of a few days or a week it recurs. This recurrence of tenderness may indicate obstructed drainage or active suppuration within the mastoid. Other circumstances of the case must determine this. When the drainage which has been free, is reduced or ceases with recurrent tenderness, the indications are in favor of obstructed drainage, while if the discharge remains free and the tenderness recurrent, we think of bony involvement within the mastoid.

Tenderness is not invariably present in mastoiditis. There may be a complete absence of this symptom. This we have

observed in cases where the external plate was very dense and where the erosion occurred in the inner plate. Absence of tenderness in a case presenting marked muco-purulent discharge and especially if such discharge has persisted for several weeks would lead us to believe that the inner plate was being attacked.

Discharge from the ear is a very important clinical guide and one upon which we lay a great deal of importance as to the condition within the mastoid. In a simple uncomplicated middle ear inflammation the discharge is moderate. When the discharge is very profuse, recurring rapidly when mopped away from the incision in the drum, or when it is so profuse that it drips off the lobule, it is a fairly reliable indication of an active mastoiditis. If this profuse discharge is of the muco-purulent type, it is safe to argue that the largest incision in the drum will not sufficiently drain the infected area.

The time limit is an important consideration in studying the symptom of discharge. All other things being equal and even in the absence of any other evidence of mastoid suppuration, if the discharge from the ear continues profuse over a period of four to six weeks, we consider it conservative to open the mastoid. We believe this to be indicated, not only from the standpoint of warding off cranialward extension, but from the standpoint of safeguarding the hearing function. The longer the suppurative process within the middle ear and mastoid continues, the greater the ultimate damage to hearing. We have all observed cases in which acute mastoiditis occurred, which were nursed along for months and which finally ceased with a permanent perforation in the drum, a much modified mucosa and a permanent marked reduction in the hearing. Again, many such cases are allowed to drift along until the condition passes over into the class of chronic suppurative ears. Certainly in either case we cannot look upon the outcome as a medical or surgical success.

In the large majority of cases of acute mastoiditis there is an accompanying, or a history of, a preceding discharge from the middle ear. Cases, however, do occur in which mastoid symptoms make their appearance and in which there is questionable evidence of a middle ear condition. These should not be classed as primary mastoiditis for the middle ear reaction may have been so slight that the drum is not opened by incision, or spontaneously by nature. The drum may be so

thickened through previous pathology that such rupture cannot occur.

Otoscopically the changes in the drum head and canal walls are suggestive. A polypoid change in the drum membrane is suggestive of a similar condition in the middle ear and mastoid. Such cases are those presenting recurring pain and which do not obtain relief through repeated incisions of the drum. Clinical experience has taught us that such cases presenting this change and requiring several incisions to relieve the obstructed drainage, are very fit cases for mastoid operation.

Sagging or sinking of the postero-superior wall of the external auditory canal is stated by some observers to constitute positive evidence of bony destruction within the mastoid and indicates the necessity for mastoid operation. We feel that such an attitude toward this single indication rather unwarranted. Taken in conjunction with other important symptoms, such as persistent mastoid tenderness or profuse discharge, it forms supporting evidence.

One of the early suggestive symptoms of mastoid inflammation is a masking of the outline of the bony mastoid tip. It is due to a low grade periostitis. This sign is elicited by standing in back of the patient and grasping the tip of the mastoid on either side between the thumb and index finger. On the side of the activity, a thickening is noted. At times a slight stiffness of the neck is present.

A symptom upon which the attending physician frequently lays so much importance and one whose absence frequently comforts the doctor to the detriment of the patient's welfare, is fever. Temperature is not always observed in mastoiditis. Widespread destruction occurs in the mastoid without accompanying fever. When present, it indicates either systemic absorption, or it is an evidence of an extension through the inner plate. Hence the presence of temperature, in association with a discharging ear, with persistent mastoid tenderness, would make the clinician determine to open the mastoid.

The X-ray examinations of the mastoid have not offered as much as we desire. It will indicate the differences in the density on the two sides. Some very elaborate localizations of the position of the lateral sinus and of bony destruction are advanced, but are not confirmed at operation. Again, almost clear bills of health have been given, but at operation marked



bony involvement is found. This is in no way a severe criticism of the efforts of the Roentgenologist. They are to be encouraged. There is much to be learned in this direction.

Evidences of extension beyond the confines of the mastoid are frequently evasive and at other times frank and spectacular, leading readily to a diagnosis. Persistent headache with hyperaesthesia, restlessness, hyperpyrexia, nausea and vomiting, chills and sweating, may indicate the beginning of a meningitis, sinus thrombosis or brain abscess. Later, as the process becomes distinctly established, a change in the symptom complex occurs. The occurrence of nystagmus and disturbances of equilibrium are evidences of labyrinthine invasion. These complications of mastoiditis are not within the realm of this paper. We merely wish to indicate that such symptoms in the presence of a discharging ear would make one look to the mastoid for the trouble.

We thus see that mastoiditis is a condition presenting varying phases and that every case is a law unto itself; that we are led to open one mastoid because of persistent tenderness in the face of free drainage through the ear; that we send another case to the operating table because the discharge continues profuse in the presence of a free opening in the drum, even though there is no tenderness and especially if the time limit is approaching. Another case is operated because the mastoid is tender and the temperature continues high after free drainage has been established from the middle ear. Another case is operated because of late or recurrent tenderness. The bacteriological findings in a given case may be a leading factor in determining the necessity for operation. We may operate quickly because the first time we observe the case there are symptoms of threatened or established extension.

We fully realize that the foregoing does not answer the question so frequently asked by the attending physician and medical students, "How long is it safe to wait before operating?" The combination of circumstances in the individual case determines this.

We might multiply various combinations of circumstances leading us to operate and back of all our scientific deductions there is a factor in clinical medicine and surgery, which is developed within each of us and which we term diagnostic intuition. Good guessing we used to say of our teachers. It is good or bad as we have developed but it is one factor in diagnosis that every clinician unconsciously uses very freely.

**EMPYEMA OF THE MAXILLARY SINUS.**

BY

G. J. ALEXANDER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 17, 1919.)

CONVINCED that more attention, closer observation and greater care should be given by the profession to the detection and care of suppuration or empyema of the maxillary sinus, I wish to present for consideration some reasons and suggestions intended to assist in a more timely recognition, particularly of the acute form, often hard to control, thus preventing as frequently as possible, the resulting insidious chronic form that in many instances is difficult to overcome even by radical measures.

The maxillary sinuses are present at birth in a rudimentary form, reaching complete development at about the twelfth year. They belong to the anterior group of the accessory sinuses, are two in number, pyramidal in shape, and each has four walls. The posterior wall is formed by the body of the superior maxilla. The superior wall, or roof, is formed by the floor of the orbit. The anterior wall corresponds to the facial surface of the maxilla, and its base is the lateral wall of the nasal fossa; the cavity being lined with a mucous membrane lining consisting of thin, closely adherent ciliated epithelium, and has its natural opening, or osteum, into the nose above the middle portion of the inferior turbinate.

With this brief resumé of the anatomy I will consider the causes and the methods of determining the presence of an infection or suppuration of the sinus, which, because of its accessibility, is the one most frequently involved.

Suppuration may result primarily from direct infection of the sinus, or, secondarily, from an acute rhinitis, influenza, a foreign body in the nose, traumatism, pneumonia, scarletina, measles, mumps, erysipelas, gonorrhoea, etc. Predisposing causes are diseased tonsils, nasal stenosis, acute rheumatism, bad teeth, galvano-cautery, nasal douches, mercurial and phosphorus poisoning, peritonitis and others. The two most common sources, however, are acute rhinitis and influenza.

Acute suppuration of the sinus so constantly occurs with or forms a part of a coryza or acute "cold in the head," that

frequently the symptoms are so similar or closely fused, that no special symptom is noticed or mentioned by the patient suggestive of implication of the sinus; that is the reason I wish to lay special stress upon the suggestion that every physician seeing a case of acute rhinitis should always have in mind the possible presence of beginning suppuration of the sinus and be on the look-out for it. Such a patient may be conscious of only a dull, heavy sensation under the eye, over the sinus, and in a more severe infection there is always pain described as neuralgic, deep-seated headache, rigor, rise of temperature, and tenderness to pressure over the cavity. Upon examination, the middle and inferior turbinates are reddened and swollen and a large amount of muco-pus or pus will be found in the inferior meatus on the floor of the nose, the pus being usually more profuse in the morning. If cleared away and the patient instructed to sit with his head bent forward, with the affected sinus turned upward for five or ten minutes, the cardinal sign will be present in the form of a streak of pus streaming from the sinus through its natural opening under the middle turbinate down over the center of the inferior turbinate. On the other hand, there may be no pus in the nose on account of edema or swelling of the parts in the nose or the lining membrane of the cavity closing the ostium; a tightly scrolled middle turbinate or the presence of only a small amount of pus in the sinus. Under such circumstances, transillumination and X-ray of the cavity may be employed, both of which are unreliable, leaving the question to be decided by the surer method, namely, irrigation of the cavity with warm sterile water, or a normal saline solution.

Another reason for my dwelling specially upon the importance of early recognition of acute empyema of the sinus, is the fact that it so frequently occurs in early life or childhood and goes along entirely unnoticed for years, until it has become a firmly established chronic affection, for which the patient as an adult at most any age, is compelled to seek the cause of distress and complications locally, in the upper respiratory tract; involvement of the ears, serious eye complications, an obscure stomach affection, loss of weight, a depleted nervous system, anemia, general debility, etc. Some of these conditions will be demonstrated in the case to be presented later.

In most instances the chronic suppurations are the result



of acute attacks, which should not be confused with the acute exacerbations of the chronic form. In both conditions as well as in the quiescent state a bacterioscopic examination of the empyemata invariably shows the presence of staphylococci, streptococci, and pneumococci.

Few cases of acute suppuration of the sinus clear up spontaneously; not many more from the use of the internal remedy, but many do respond to the combined use of the internal remedy, vaccine therapy, local treatment to the nose, and irrigation of the sinus. If the condition does not subside after about eight or ten washings, conservative surgical measures are instituted in the nose to facilitate drainage; this together with frequent washing of the sinus will bring about resolution in a number of cases in from one to four months. If the pus persists up to and beyond this period, a year at the most, it must be regarded as chronic and treated accordingly.

This form of suppuration for the most part resists all forms of conservatism and demands surgical interference of a radical nature, in which the sinus is opened and its contents removed. These may be in the form of a thickening of the lining, polypoid degeneration, whereby the entire cavity may be filled with polyps, or there may be necrosis of the soft parts or even the bony walls; healing is encouraged by local treatment of the nose and irrigation of the cavity. While this method is usually attended with cure, there are occasions where it fails.

There are several abnormal anatomical factors frequently present in the nose that have the effect of both predisposing the sinus to infection and complicating an established suppuration. These are: Deviation and thickening of the septum, a large septal ridge and septal spurs, hypertrophy and hyperplasia of the turbinates and large cystic middle turbinates.

In the first place, because of contact with and pressure of the parts upon one another, there results turgescence or congestion of the parts, causing and perpetuating a chronic inflammatory state of the mucous membrane in the nose, which in turn extends to the membranous lining of the cavity, weakening and increasing its susceptibility to infection.

Secondly, they inhibit natural drainage of the sinus by causing a narrowing or stenosis of the nasal cavity and obstructing the natural outlet or ostium of the sinus.

In either case, to remove the sources of irritation and obstruction to drainage, surgical measures must be employed;

for example, a submucous resection of the septum, turbinotomy and removal of the hyperplasias. This, too, is imperative to establish accessibility for either topical or surgical treatment of the diseased sinus.

Complications in the nasal chamber resulting from the influence of suppuration of the sinus, and those in the nose complicating sinus disease are present in a number of cases, many of which will be found in the following one:

CASE 1.—January 21, 1919, female, E. B., age 21 years, referred by Dr. John Stewart. At the age of three years she had a hard attack of pneumonia; a few years later, or about the age of six, her mother noticed that her nose began to discharge; at the age of ten years she had mumps and measles. About the same time there was a marked increase of discharge from the nose and she was troubled with lacrimation of the right eye, which Dr. L. Webster Fox said was the result of some trouble in the tear duct or the sac. The amount of discharge from the nose remained about the same until one year ago when she contracted a severe cold in the head; since then the discharge has been profuse, watery and worse on the right side. About three months ago she first noticed an offensive odor in the nose and a bad taste in the mouth; these, with coughing and gagging, have persisted and are worse in the morning, as is also the discharge. Along with this there have been frequent fresh colds with a great deal of sneezing and a desire to blow her nose. During the past month her condition has become aggravated; she says something prevents her from breathing through the right side of her nose.

*Examination—Nose.* There is a moderate deviation of the septum to the right, and its upper portion is markedly thickened; the tissues in the left side of the nose are thick, soft and spongy; all parts in both sides of the nose are atrophic in appearance. There is a profuse amount of muco purulent secretion in the back part of the right side running down over the posterior end of the inferior turbinate, which, when cleaned away, is quickly supplanted by another large amount, as if it were coming from the sphenoid sinus. Behind the posterior end of the inferior turbinate attached to the lateral wall of the pharynx by a short pedicle is a large fibrous polyp the size of a pigeon's egg, acting as a ball valve to the posterior choana; the pedicle is short, soft and amber color, and the distal end or body of the mass is round, regular in outline, gray and hard to

touch. The uncinate process on either side is abnormally large, especially the right one, which is so high that it has prohibited the development of the middle turbinate in its interior half which is absent, and the posterior half plainly visible.

As a supplementary means of diagnosis, transillumination was employed, and showed both frontal and both maxillary sinuses clear, no shadows or dullness whatever. This test was followed by washing out the frontal and maxillary sinuses; both frontal sinuses were negative, and a large amount of thick greenish-yellow fetid pus was washed out of the maxillary sinuses.

The bacterioscopic findings showed an abundance of staphylococcus albus and bacilli.

The first procedure in the treatment of this patient was to straighten the septum by doing a submucous resection, to make more room on the right side of the nose for subsequent work, and to facilitate drainage of the right maxillary sinus. At the same time the septum was operated, the fibrous polyp on the lateral wall of the pharynx was removed through the right side of the nose. Two weeks later under general narcosis a bilateral Denker operation was performed, which means that the anterior part of the antra-nasal wall on either side was removed and all the disease tissue curetted from the cavities.

The cavities contained considerable pus; the membranous lining was markedly thickened and oedematous, particularly on the floor and antra-nasal walls. The cavities were packed with iodoform gauze, the wounds in the canine fossage and an opening allowed to remain on each side in the lateral nasal wall for drainage.

The after-treatment consisted of regular frequent irrigation of the sinuses and local treatment to the nose. In two months the right sinus was negative and healed and the left one almost, and at this time is not entirely negative, because the patient has not been able to come regularly for treatment during the last three months. The nose is perfectly clean and free from pus on both sides. The patient feels much better; stomach and nerves are again normal, has a better appetite and has gained weight.

In summarizing, I want to mention briefly several points well illustrated in this case. For example:

(a) We have found the conditions of atrophy and polypoid hypertrophy well established, existing in the nose simultaneously as a result of suppuration in the sinus.



(b) The unusual enlargement of the uncinate process which in this instance interfered with drainage of the diseased sinus and caused one of the middle turbinates to be deformed.

(c) Wherever there is a deviated septum, especially when it is directed toward the side on which the diseased sinus is located, the deformity must be corrected to allow easy access to that side of the nose and the sinus, and to overcome possible obstruction to drainage of the sinus.

(d) A maxillary sinus involved by a chronic suppuration can scarcely ever completely recover without the aid of a radical operation.

(e) This case represents a typical example of an empyema of the maxillary antrum contracted in childhood and without treatment on account of the failure of a number of physicians to look for it.

I do not wish to criticize, but were I to do so, it would be for the purpose of construction and not destruction; hence, I want to remind the practitioner that he should look for the cause of the trouble, no matter if he can recognize the condition or not; he will at least be able to tell that there is something radically wrong and he will have learned something for his trouble.

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### KALI PHOSPHORICUM IN NEURASTHENIA.

BY

CRAWFORD R. GREEN, M.D., TROY, N. Y.

THE reactions of man to his environment change as does all else in nature. Food that is adapted to the needs of one generation may not be altogether adapted to the needs of the next. Susceptibility to disease varies not only with the changes in the characteristics of germ life, but also with the development of increased or lessened resistance on the part of man. We know what a remarkable racial immunity against tuberculosis has been developed by the Jews through centuries of closely confined urban life. We know how differently the virus of measles acts upon virgin soil and upon peoples who have been long accustomed to it. We know in what an attenuated form the *spirochaete pallida* may manifest itself in modern civilization as compared with its ravages in a preceding age. Response to various stimuli is bound to make different mani-

festations in different generations. What would be a profound nerve shock in one generation may, because of its frequency or familiarity, make but little impression upon the next. On the other hand, the exigencies of modern life may well be imagined to make such a drain upon nerve vitality as to produce syndromes entirely unknown in an age of slower transportation, lower tension, and lesser competition.

Thus we see that the characteristics of morbid conditions will by no means remain constant. The description of a disease or a set of symptoms that was made twenty, forty, sixty years ago may seem to the unthinking of today to be inaccurate, because it does not altogether fit the condition as we see it in our time. This, however, does not necessarily mean that the observations of the older clinicians were any the less accurate than our own; it may just as well mean that the environmental influences of the life of former times so impressed itself upon morbid states as to produce different symptom complexes. What were minor symptoms in one decade may be major in the next; symptoms that are rare at one time may become common at another.

Similarly, the genius of the remedy in its applicability to cure may undergo slow but nevertheless certain changes. That is to say, some of the remedies that our predecessors found to be among the most important in their armamentarium are comparatively little used today, not because they are any the less valuable or any the less curative upon their indications, but because they are less frequently indicated. Conversely, some of the remedies in daily use by the best clinicians in our day were little used in the preceding generation; not that the older observers had not proved or did not understand them, but because the symptoms calling for their exhibition were less frequently in evidence.

I wish particularly to emphasize this fact for the reason that it is so frequently overlooked. Homœopathy is based upon a definite, fixed, scientific law. Yet homœopathy is not immutable like some dead language, but is a living science and susceptible to influences that produce variations of applicability just as are all other vital things. Homœopathy therapeutically, however, is often taught, discussed, written about as though there could never be any more variation in the relative importance of various remedies or of the individual symptoms of those remedies than there could be in the architecture of ancient Greece. Time tempers all living things. Even man's

anatomy shows changes which, though incalculably slow, are none the less sure.

Among the commonest classes of patients one meets in the general practice of medicine are the sufferers from neurasthenia. And among the best tools that have been given man to help him in the struggle against morbid states are the homœopathic remedies that are indicated in neurasthenic conditions. I have read very extensively what the older homœopathic writers have had to say regarding the remedies which they considered applicable to these conditions, and I have studied at first hand great numbers of these patients. From my observations I have concluded that there should be a revision of our ideas concerning both neurasthenic conditions and the homœopathic remedies applicable to their cure. Few physicians who are presumed to have knowledge of homœopathic therapeutics appear to be making the best use of the materia medica which is so richly endowed with remedies to serve them; and many who have the theoretical knowledge seem to lack the faith, or the courage, or the vision to use them well. We run riot with all sorts of nerve tonics, nerve sedatives, and proprietary drugs of the crudest sort, shamefully neglecting the very reason for our existence as a separate body of therapeutists. Why one should profess to be a homœopathic physician and continue to practice everything except homœopathy, I have always been at loss to understand.

It is probably a safe assertion that neurasthenic conditions have never before been quite so prevalent as they are today. The more complex the mode of living and the keener the competition in the struggle for existence, the more is the strain to which the nervous mechanism of the individual is necessarily exposed. Neurasthenics and near-neurasthenics, recognized and unrecognized, are with us everywhere.

Homœopathy has given us many remedies of the greatest value in combating the neuroses, but none other seems quite so frequently indicated or of quite such great value at the present time as *kali phosphoricum*. *Kali phosphoricum*, however, does not occupy a particularly impressive position in the materia medica. It is not an old remedy. It was introduced as one of the tissue remedies of Schuessler, and it was first proved by H. C. Allen in 1892. But it seems not to have been accorded a very great prominence in the treatment of nerve disorders, and it is by no means difficult to find able and busy homœopa-



thic contemporaries who use *kali phosphoricum* but little, if at all.

I do not intend, in this brief essay, to give an exhaustive resumé of symptoms, or an intimate exposition of the remedy as a subject of materia medica, but, rather, to stimulate an interest in the study of a remedy which will be found well worth while. The symptoms which are the essential, prominent, characteristic symptoms of *kali phosphoricum* are symptoms that patients bring to us every day for relief.

Depression and exhaustion are always present in the *kali phosphoricum* patient. He has pronounced lethargy and lassitude. He is worn out and cannot "carry on." Nervously, he has reached the end of his rope. He is exhausted after moderate mental effort; his memory is failing; he has difficulty in remembering names or words. He is in a constant worry and makes mountains out of mole hills.

He has a feeling of weakness in his limbs; his feet are fidgety; there is a trembling sensation in the muscles of his legs. Numb sensations are very common, particularly numbness of the finger tips. Backache is very prominent among his complaints. He has drawing pains in the back of the limbs, which are relieved by motion. In the early morning he is likely to be disturbed by rheumatoid pains in the arms or legs, which usually pass off during the forenoon.

He is troubled by vertigo, with a sensation of pressure on the brain. He has head noises with ringing in the ears. He commonly suffers from pain in the back of the head and neck. He is unable to sleep; he has to urinate frequently; and he is often annoyed by itching of the skin, particularly the head.

The patient's digestion is usually impaired. His appetite is good, but the sight of food takes it away. He often experiences nausea after eating. His abdomen is distended and he belches much gas.

These few generalities, standing out so conspicuously in the symptomatology of the remedy and in the histories of our cases, indicate how desirable a close study of *kali phosphoricum* must be. *Kali phosphoricum* certainly has a big work to do, if only it be given the opportunity.

The third decimal trituration is usually employed by the writer and the average dose is two grains every three hours. Occasionally, an aggravation results from the third decimal. In these cases the twelfth decimal has given satisfactory results.

## EDITORIAL

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### THE OCCASIONAL OCCURRENCE OF SEVERE SYMPTOMS DUE TO IMPACTED CERUMEN.

THE *Journal of the American Medical Association* for August 21st, contains a short clinical note by Dr. Kaunitz, of New York City, reporting an example of unusual symptoms caused by cerumen in the auditory meatus. Briefly, the symptom complex presented by the patient included nausea, vertigo, vomiting, diarrhoea, nystagmus, and weakness. The general condition of the patient suggested a serious illness. All of the clinical phenomena disappeared promptly on the removal of impacted cerumen. For many years we have been in the habit of impressing upon our students the occasional occurrence of obtrusive symptoms due to cerumen and other foreign bodies in the auditory meatus. We have not hesitated to depict in no uncertain terms the mortification which must be incurred by the physician who fails to discover such a simple disease-producing agency. Some notable examples of the kind occurring in our experience may herewith be noted:

One patient suffered from an obstinate dry cough. Most careful physical examination and various clinical investigations by a number of physicians in succession failed to throw any light on the case. Finally a routine examination involving the entire patient resulted in the discovery of a piece of split pea in the auditory meatus. The removal of this resulted in a cure. Any one who has had any experience with the ear speculum cannot have failed to notice the dry cough when that instrument has been inserted; or again, the occurrence of a cough attendant upon aural manipulations.

The most important symptom due to aural irritation, however, is vertigo, and this in turn, is capable of giving rise to secondary phenomena as in Dr. Kaunitz's case. Years ago, one of our patients was declined by an insurance company as an undesirable risk. His main disability was a persistent vertigo. Both ears were thoroughly obstructed by cerumen, the removal of which cured the vertigo. In this instance, a noteworthy condition was the difficulty attendant upon the

cleaning of the meatus, the slightest manipulation of which resulted in aggravated vertigo.

Our most important example of the disease-producing power of impacted cerumen, was that of a middle aged man who had persistent vertigo and "stomach trouble" covering a period of over a year. He had consulted various specialists. He had been refracted time after time; he had had his stomach washed out by a stomach specialist three times weekly for an entire winter; and was cured promptly by the removal of a small portion of cerumen impacted against the membrum tympani. One can readily conceive of the undesirable advertising obtained by the various attendants upon this patient by reason of their failure to discover the very simple cause of the symptoms.

The moral of all this is obvious: More mistakes are made by not looking than by not knowing; examine all patients thoroughly; do not hesitate to make the painstaking inquiries into all functions and disturbances thereof.

The unusual may happen at any time and to anybody. Cough is a prominent symptom of pulmonary tuberculosis and of pneumonia; but each of these diseases may occur without any cough whatever so far as the history of the case may go. Certainly, there are many instances in which cough of tuberculosis or pneumonia is so mild as to escape attention unless careful inquiry or observation is made to determine its presence.

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#### THE MINERAL SALTS OF COW'S MILK.

BOSWORTH and Bowditch, of the Boston City Floating Hospital, have made an extensive study of the problem of infant feeding from the standpoint of the mineral salts. They have shown that while calcium salts are found in a much higher percentage in cow's milk than in human milk, still all of this calcium is not available from the standpoint of assimilability, most of it being eliminated in the stools as insoluble phosphate and calcium soaps. Were this not the case the infant might suffer from the entrance of an excess of organic calcium combinations into the body fluids with subsequent toxic results. Paradoxical as it may seem, the addition of limewater



to the milk formula instead of increasing the available calcium in such a mixture actually lessens it by bringing about a precipitation of calcium phosphate from the milk.

Potassium salts on the other hand are deficient in cow's milk and, therefore, in prescribing a milk formula for an infant we should always aim to give no less than 1.75 per cent. to 2 per cent. protein in order to insure the presence of a sufficient amount of this salt. In high-protein formulas some of the calcium may be eliminated by boiling the milk, which process also precipitates some of the calcium phosphate from the milk.

C. S. R.

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### STATE HEALTH INSURANCE.

WE have written several times on this subject, but feel that it should be kept before the attention of the medical profession so that careful thought will be given to it by the individual physician and organized medical bodies. It is practically sure to be a live issue during this coming winter, when the Commission on Health Insurance, appointed in Pennsylvania, is to present its second report to the Legislature, and this report will likely be followed by a bill to make Compulsory Health Insurance an enactment in Pennsylvania; such a bill, if not coming from the Commission may be presented by some agitator seeking notoriety.

We are absolutely opposed to any such enactment, believing that it is class legislation; that the class whom it will benefit do not, as a mass, want it; that the enormous amount of money it would cost the State, if spent in expanding the health agencies now in existence, would produce far more beneficial results in relieving the sick problem, which is, after all, a real problem; that the amount of sickness amongst employees will not be materially reduced by such a law, but rather that malingering, to a certain extent, will be fostered; that the medical attention rendered under such a law will be less adequate and efficient than at present; and that medical education will recede from the high standards of which we in Pennsylvania have a right to be justly proud, as the incentive for scientific progress will be lacking.

If Compulsory Health Insurance is the solution to the eternal sickness problem, then we, as members of the public

community, as well as medical men, must support it, but this is doubtful, as the experience in all foreign countries has so far been the reverse. Therefore, let each of you carefully study the situation, the laws proposed (but not passed) in other States, especially the so-called Davenport bill in New York, so as to form your judgment.

If it is advisable to have some such law it behooves us to carefully arrange proposed medical schedules for fees, consultations, specialists' services, freedom of choice by patients of their medical attendants, and other purely medical affairs.

At a public meeting held in Philadelphia in May by the Pennsylvania Commission on Health Insurance, the usual suggestions were made by several speakers in regard to the medical part of such a bill, especially by one professional investigator, who, not content to advise in his own State, must needs go to New York and now to Pennsylvania to insert his forceful but rather devious arguments into the affairs of other States. According to these statements the medical profession is to be the "goat" of the act, if you will permit us, and pardon the slang. The suggestion is that the fees and schedule be arranged *after* the passage of such a bill, by the Commission, who will administer the proposed law—a politically appointed Commission, which, even if containing a medical man on the Commission, is sure to be dominated by the interests back of the law. And the experience of Pennsylvania physicians, still smarting under the injustice of the Pennsylvania Workmen's Compensation Act, is not such as to put much dependence on equity or justice in another politically appointed Commission. The medical profession will be under-paid, surely.

The following quotations from a report of a Committee of the New York Chamber of Commerce, opposing the Davenport bill in New York, may be of interest:

"It is opposed to sound public policy in a democracy, in fostering objectionable class distinction and a dangerous tendency toward a stratification of industrial society.

"It is opposed to public policy in a further encroachment on private rights and privileges, including the most personal concerns of the individual, and the supervision, control and direction of the person in matters of health and welfare.

"It is a danger to democracy, in that the promises made are impossible of fulfilment, and on this ground will ultimately create an unwholesome industrial unrest.

"It is a delusion in that the poorest poor, who are most urgently in need of sympathetic medical and financial support and assistance, are largely, if not wholly, outside the sphere of social insurance activities of any and every kind.

"Such demand for compulsory health insurance as exists has been artificially created by a skilful propaganda.

"It is at best a palliative, and does not reach the seat of the difficulty.

"It does not promote the health of the individual, but rather fosters a tendency toward malingering and an undue prolongation of minor ailments for the purpose of wrongful gain.

"Experience in other countries shows that medical treatment under its rules result in a standardized method of mediocre practice—the doctor who gives his whole time to the service reduces his profession to a mere trade; the doctor who gives only part of his time to the practice is bound to give it indifferent attention.

"Experience abroad has also shown that medical practice under this system tends strongly toward a system of public medicine, opinion being divided as to whether under such a system private practice should be allowed at all, or whether the system should be universal; in other words, whether the doctor should become a State employee, leaving private practice and the work of the specialists to the few who are unwilling to submit themselves to State control.

"All the estimates in England have been more or less at variance with actual experience. The State contribution has been very much greater than had been assumed would be necessary at the outset.

"Compulsory health insurance is an elaborate bureaucratic scheme which controls wage-earners' lives and wage-earners' incomes. The hope held out that the institution to be created will be thoroughly democratic and, apart from the overhead charges, self-sustaining, never has been and probably never will be realized. Control of essentials soon passes into the hands of the State authorities, with a corresponding increase in the power of bureaucracy."

On the first night of the meeting of the Pennsylvania State Homœopathic Medical Society, Tuesday, September 21st, at Harrisburg, an open meeting will be held and this subject thoroughly discussed from the medical point of view, its scope,



and its possible effect on medical education and progress, and the practice of medicine. Make a special effort to attend that session, and become conversant with the present status of State Health Insurance.

W. M. H.

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#### THE PENNSYLVANIA STATE SOCIETY ONCE MORE.

AGAIN we remind our readers that the next annual meeting of the Homœopathic Medical Society will be held at the Penn-Harris Hotel, Harrisburg, September 21st to 23rd, inclusive, with Dr. Robert L. Piper, of Tyrone, in the chair. As usual, we say that never was there a meeting of greater importance: only in this particular case, we mean to say it with more than usual emphasis. The burning question of the day is compulsory health insurance, which, as we have already stated, is a menace to humanity and to the growth of medical science. Certain idealists, and there is no greater danger to the community than an honest idealist let loose, are pushing the matter. They have been defeated in New York, and, with the experience gained by such defeat, they come to Pennsylvania more determined than ever to pass the pernicious legislation. The medical profession must speak in no uncertain tones concerning the measure. For with the object of defeating the Compulsory Insurance Bill the first step must be taken, that of making the attendance at Harrisburg as large as possible. It is not to be a case of "letting George do it," but of insisting that everybody shall do what he can to compass the defeat of the bill.

The next thing is to increase our enrollment of new members to the largest possible. The membership committee has issued a pamphlet giving the names and addresses of every homœopathic physician in Pennsylvania whose membership in our society is desirable. All of these men have been served with membership blanks, and now we ask our readers to con the list carefully, and finding thereon any particular physician with whom they have influence, to exert said influence to secure him or her as a member. It matters not whether that individual has previously been a member of the society or not, and has severed his connection with the society for one cause or another. We wish to have a complete enrollment as

members of every homœopathic physician in the State of Pennsylvania. If our physicians will but work, and if our membership will but come to the Harrisburg meeting, they will learn the value of our society to themselves.

Finally, to make sure that our members shall have comfortable accommodations, let them engage rooms in advance of the meeting. This may be done by writing to the Penn-Harris Hotel, or to Dr. Hartman, 801 North Third Street, Harrisburg, Pa.

Our meeting at Harrisburg ten years ago was larger than any medical meeting ever held in that city by any medical society in the State. Let us eclipse that occasion. The Homœopathic Medical Society of Central Pennsylvania will act as hosts for the occasion, and have everything ready for us.

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THE RESECTION OF IMPASSABLE STRICTURES OF THE URETHRA, WITH A REPORT OF THREE CASES.—S. H. Harris (*Med. Jour. of Australia*, 1920, I, 90) has adopted a plan of treatment based upon the principle that the perineal portion of the male urethra may be slipped upon its floor to any desired extent, and thus converted into a ribbon, the damaged portion being then resected and the ends of the ribbon sewed together; and that, if the urine is not allowed to contaminate the wound, the urethra will naturally resume its tubular form in the course of time. A cystotomy is first performed, the bladder being drained and irrigated for at least a week before performing the operation on the stricture. Except for suturing the ends of the ribbon of urethra together after the removal of the strictured area, no sutures are needed, the sides of the incision falling together naturally when the thighs are brought in apposition. Suprapubic drainage is discarded at the end of ten days. A large sound is passed at the end of three weeks. The operation was followed by complete recovery in three cases reported.

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NEPHROLITHIASIS.—M. Seres (*Pres. de la clin., Madrid*, 1920, VII, 264) states that in this affection characteristic changes are produced in the form, appearance and color of the ureteral orifices, and in the ejaculation and appearance of the urine; although these changes are neither so marked nor so constant as those caused by ureteral stone. If a cystoscopic examination is made after an attack of renal colic in which a calculus has been passed, the margins of the orifice are seen to be surrounded by a zone of ecchymosis, beyond which there is an edematous zone. If the stones have not been passed but are still present, the lips of the ureter are enlarged and pouting. Secondary infection will often modify this picture. The number of ejaculations of urine from the ureter may be reduced to two or three a minute in cases of hydronephrosis and pyelonephrosis, their force, also, being much decreased. The ejaculations may, in some instances, be prolonged, so that the urine dribbles almost constantly from the ureteral orifices. When no complications are present, the urine is clear; but infection causes turbidity, and each ejaculation lessens the transparency of the bladder contents.

## GLEANINGS

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### MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

**DISINFECTION OF THE ORAL MUCOSA WITH CRYSTAL VIOLET AND BRILLIANT GREEN.**—Berwick, of the University of California, has made laboratory and clinical studies concerning the action of these remedies. Clinically he has reached the conclusion that solutions of crystal violet and brilliant green may be easily applied to the gums and even to the deeper portions of the oral cavity. The diffusion and penetration of the dye is considerable. The clinical data reported by him are wholly in keeping with the results that various observers have obtained with dyes as antiseptics for other parts of the body. In every instance, the case was benefited by the dye. Extractions, old discharging sinuses and old infections, yield completely to the treatment.

Solutions of crystal violet and brilliant green appear to have no lasting beneficial effect upon pyorrhoea. The only result obtained was merely a temporary diminution in the severity of the symptoms.

Berwick's general conclusions were as follows: Brilliant green and crystal violet in solution together (1 per cent. of each in 30% alcohol) are very efficient, mild antiseptics. This combination has very little if any harmful effect upon the delicate mucous membrane of the mouth.

Clinical observations indicate that these dyes together in alcohol act not only as an antiseptic, but also as a mild stimulant to newly forming granulations, both by keeping down contamination by oral organisms and by destroying or inhibiting the growth of organisms initially present.—*The Journal of Dental Research*, Vol. II, No. 1.

**THE VARIETIES OF TRIFACIAL NEURALGIA.**—The particular variety of trifacial neuralgia generally known as tic douloureux has occupied so much attention among physicians and surgeons because of its special features and intractable character, that sight has been lost of the fact that neuralgia of other varieties may invade the face. Harvey Cushing now directs forcible attention to this fact, and makes an arbitrary division of the major and minor facial neuralgias, and describes no less than five types which may be relegated to the former division. Their differentiation in practice is of the highest importance, as it is evident that surgical treatment applicable to one is unquestionably inappropriate for the others.

(1) Neuralgias accredited to the Sphenopalatine (Meckel's) Ganglion. This is also known as Sluder's neuralgia, which was described by its discoverer as follows: "The neuralgic picture is pain in the root of the nose and in and about the eye, in the upper jaw and teeth (sometimes lower jaw and teeth) extending backward under the zygoma to the ear, frequently making earache and pain in the mastoid; but severest at a point 5 cm. back of the mastoid, extending thence to the occiput, neck, shoulder blade, shoulder, breast, and when severe to the forearm, hand and fingers, with sometimes a sore throat on that side. Rarer additions to this picture are itching of the skin of the upper extremity, taste disturbances (parageusia), a sense of stiffness and muscle weakness in the upper extremity and fortification scotomata. Mild cases are described as a sense of tension in the face and stiffness or rheumatism



of the shoulders. It may appear as a constant pain with exacerbations, or it may stop and reappear cyclically as a migraine; or it may stop and reappear with stabbing sharpness as a tic."

Failure to recognize these cases when seen has led to unwise surgical interference with the Gasserian ganglion, with of course entire failure of relief or even of cure. Cases of this kind are not infrequently subjected to series of alcohol injections and nerve operations truly tragic in their details.

2 Post-Zoster Neuralgias Trigeinal and Geniculate. The cases belonging to this class should not fail of recognition if care is taken to obtain a detailed history of the advent of the pains and the clinical events leading thereto. In the majority of instances, the markings on the skin suggest the healed zoster, and make a diagnosis clear. In others there is nothing to suggest such a condition, and inquiry, oftentimes necessarily direct, makes evident the true nature of the illness.

3 Neuralgias accredited to the Geniculate Ganglion Hunt's Neuralgia. In 1907, Ramsay Hunt directed attention to the clinical importance of the sensory radicle of the facial nerve exclusive of its gustatory function. He has emphasized the fact that discomforts may occur in the auricular skin fold, which he attributes to the geniculate ganglion, and he even speaks of a primary tic douloureux of the ear among other varieties of otalgia. Hunt has furthermore collected many examples of auricular herpetic neuralgia, unquestionably geniculate in origin, some of which have been followed by discomforts similar to those succeeding zoster elsewhere. The otalgias which have been attributed to geniculate disease, are said to be at times very severe, and what is important in the present connection, the discomforts may actually spread forward over the trigeminal field and down the neck and shoulder, so that they may easily be confused with other pseudo trigeminal neuralgias. Cushing remarks concerning the neuralgias of this class: "It would seem in view of the situation of the geniculate ganglion and its necessary frequent implication in infections of middle ear, that otalgias from this source would certainly be as frequent, if not more so, than similar conditions in the field of the trigeminus. Certainly the two must be very different in their natures, and to avoid confusion, it would seem unwise to speak of the geniculate syndrome and its otalgias as tic douloureux. It must be borne in mind however, in the consideration of otalgias that the trigeminal field has been shown to include the tragus, the anterior wall of the auditory canal, and part of the tympanic membrane, and in many cases of trigeminal neuralgia originating in the mandibular division, the inaugural pain in the auriculo-emporal neighborhood is often described as starting in or near the articular process of the jaw."

(4) Painful tic Convulsif. This variety Cushing believes to be an undescribed condition, of which he has seen but three definite cases. The clinical feature is the association of severe trigeminal pain with the spasmodic contractions of the face, and the condition may at times resemble true trifacial neuralgia so closely as to lead to diagnostic error.

(5) Neuralgias from Tumor Involvement. These are quite uncommon. To know their possible existence is forewarned clinically. In such cases there are almost invariably combinations of symptoms to indicate the presence and location of the tumor. Cushing divides these cases into four groups as follows: (a) Tumors in the cerebello-pontine recess, which press upon the trigeminal root; (b) those involving the ganglion by direct pressure from

above; (c) those arising in the pterygoi fossa or in the temporal bone, which press against the ganglion from below; and (d) those arising from the envelopes of the ganglion itself.

Cushing's article closes with some pertinent remarks concerning the minor trigeminal neuralgias. An apology is herewith offered for the length of this abstract, but the importance of the subject—virtually every physician of any extended experience must admit his bewilderment at the varied types of facial neuralgia coming under his care—justifies the space occupied, and the time taken in the preparation.—*American Journal of the Medical Sciences*, August, 1920.

**SYPHILIS OF THE HEART AND CIRCULATION.**—Chapman remarks that there are reasons for expecting visceral manifestations of syphilis to appear at an unusually early period in the case of those who have gone through the strain of the late war. Cases of atheromas and tabes occurring thus early have already been reported, and it is fair to assume that the heart and other internal organs are equally prone to premature degenerative changes. The lesson to be derived is that when a patient with organic heart disease comes before us and there is no history of the more usual infections, syphilis should be suspected and confirmatory evidence diligently sought for, especially in patients at or after middle life. When the cardiac symptoms are not urgent, it is advisable to prescribe a period of rest, together with a short mercurial course, before proceeding to the administration of the more direct cardiac remedies.—*American Journal of Syphilis*, July, 1920.

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## DERMATOLOGY

Conducted by RALPH BERNSTEIN, M.D.

**ARSENICAL KERATOSIS.**—W. McMurray and L. P. Johnston, of Sidney, report the case of a man 33 years old who for five years had suffered from severe keratoderma due to ingestion of arsenic over a long period. According to the patient, he started to have fits 14 years prior to the time of observation, and had been taking a mixture since that time for the purpose of warding off the attacks. In the hope of relieving his condition, the skull had been trephined without success. During these years the patient had suffered many attacks of vomiting and diarrhoea, no doubt resultant from the arsenic in the prescription which he had been taking. He had well marked keratoderma of the soles and palms. These thickened areas were covered with punctate keratoses. The body, especially the trunk, showed the characteristic rain-drop pigmentation due to arsenic, and the patient also showed the silver tongue of chronic arsenical intoxication.—*Med. Jour. Australia*.

**ARSENICAL ERUPTIONS.**—Jamin, while in the dermato-venereal center, at Tunis, observed 29 cases of arsenical eruption which resulted from an effort on the part of soldiers to avoid military service. These men had taken a mixture of thapsia roots, honey and arsenic. One dose was enough to produce the desired effect upon the skin which appeared on the second day after the ingestion. The onset in all the cases was very much the same. Gastro-intestinal symptoms first made their appearance and usually came on suddenly. This was followed by an erythema consisting of lentil sized red areas, rounded and sharply outlined, and disappearing under pressure.

The site of predilection was on the extensor surfaces of the four extremities. On the day following the onset the eruption became confluent on the extremities and continued to generalize over the entire cutaneous surface. The condition then took on the appearance of a primary acute erythroderma.

The cases divided themselves into two classes. One exhibited a mild form which was characterized by lack of fever, absence of albuminuria, and an eruption of a morbiliform type which was limited to certain areas and did not involve the mucous membrane. This form usually cleared up in about three days, leaving nothing but a furfuraceous desquamation similar to that of scarlet fever. There was no itching, but after the disappearance of the eruption there was some pigmentation.

The other form was much more intense. All the phenomena of the mild form was greatly accentuated and there was marked systemic disturbance. The onset was accompanied by severe headache, vomiting, diarrhoea, and sometimes by epistaxis. The fever reached 40 C. At times the erythema was papular, occasionally it was in well defined plaques suggesting erysipelas; at other times it had the appearance of multiform erythema. One case had lesions closely resembling those of pityriasis rosea. In some of the cases itching was more or less intense. The eyelids, lobes of ears and the elbows sometimes showed soft phlyctenules containing a yellow, serous fluid. In this intense form the mucous membrane was frequently involved and exhibited bullae analogous to those of the skin.

The author was unable to determine the role played by the thapsia in the production of this dermatitis, but one of his colleagues in Tunis said it was possible to produce similar eruptions by the use of thapsia alone.—*Bull. Soc. franc. de dermat. et de syph.*

**PSORIASIS AND DIET.**—That there is a marked retention of nitrogen in psoriasis, leading logically to the conclusion that a withdrawal of proteins or nitrogenous foods from the diet of such patients would help them, is shown by the work of Shamberg and his co-workers. Pusey reports a case of psoriasis observed in a young woman who had been a partial vegetarian since childhood, from which I quote: "For the last four years she has eaten a very small amount of meat, nothing but pork chops and beef; she eats sparingly of these, and never but once a day, her reason being that she does not care for meats. . . . She is very fond of gravies."

According to Shamberg, a reduction of nitrogenous food alone was not sufficient to cause the disappearance of the lesions. He claims to have found it necessary to keep his patients in the hospital in order that the food might be weighed and controlled and the nitrogenous foods thereby reduced to the required minimum, as very few patients sufficiently understand the importance of absolute adherence to instructions which are necessary to secure desired results. According to Shamberg, a patient eating "sparingly of these and never more than once a day" is not on a protein free diet and the patient might just as well eat as much protein as wanted because no therapeutic effect will be noted. It would, therefore, appear that the c reported by Pusey is not necessarily evidence tending toward the view that the absence of protein in the diet is of no value in the treatment of psoriasis.—*Journ. Cut. Dis.*

**CYSTS OF THE LABIAL MUCOUS MEMBRANE.**—R. L. Sutton made a search of the dermatologic literature and failed to find any mention of this



disorder, although it is more or less frequently encountered. From a clinical standpoint, the simple retention cysts of the lip vary in size from that of a pin-head to that of a small hazel-nut. The most common location is the lower lip at a point overlying the left cuspid tooth. The lesions are somewhat paler than the normal mucous membrane and are painless. Frequently their presence is discovered through accident. When incised a whitish, glairy, ropy fluid escapes. If the opening is allowed to close the cysts promptly refill. Of eleven cases observed nine occurred in men, and in every instance the lower lip was the one involved.—*Journ. Cut. Dis.*

PAPILLOMATA OF THE BUCCAL MUCOUS MEMBRANE.—Simple papillomata are usually found about the anus, the genital region and on the scalp. Papillomata of the mucous membrane of the mouth, however, are extremely rare. Brocq is about the only writer who mentions them. Simon and Gastinel describe papillomata occurring in the mucous membrane of the cheek along the line of the molar contact, and at the mucocutaneous junction of both the upper and lower lips. The lesions varied from opaline, flat neoplasms the size of a pin-head, and resembling verruca plana juvenilis, to sessile tumors. Interspersed with these tumors were typical and numerous lesions which were first described by Fordyce, and which are now known as Fordyce's disease.

Histologically, the tumors consisted essentially of a hyperplasia of the Malpighian layer, together with an increase in the corneous layer. There were numerous karyokinetic figures. In places perivascular infiltrations of plasma cells were found.—*Ann. de dermat. et de syph.*

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## SURGERY

Conducted by J. D. ELLIOTT, M.D.

CALCULI IN THE SALIVARY DUCTS.—Erdman discusses five cases of calculi which he has removed from Wharton's duct and the parotid gland. While recognizing the rarity of this condition he believes its possibility should be borne in mind and a correct diagnosis will save the surgeon from the embarrassment of a futile operation for a supposed lymphadenitis.

The classical pictures of "colique salivaire" of the submaxillary region is that of intermittent swelling of the salivary gland, or of the duct behind the stone, accompanied by sudden severe pain in the floor of the mouth, tongue and side of the throat, all of which occurs during meals or may be excited by the mere sight of food. This tumor persists until there is a sudden discharge of saliva, which in a case reported by M. Reverchon would spout a jet of saliva, occasionally at meals, to a distance of from 30 to 50 cm. In some such a history runs back over a period of ten years or more; but in such cases the diagnosis should be very easily made. In many others the history is short, of a few months, or a few weeks or even only a few days.

Examination of the floor of the mouth or cheek will usually show some change at the exit of the duct, a purulent discharge or swelling and redness. There may be a visible swelling along the course of the duct, or bimanual palpation may reveal a cystic mass or even the actual presence of the calculus. In my experience with Wharton's duct, the stone is very likely to be rather far back, about opposite the last molar tooth.

Probing the duct requires some application and perseverance, but may

yield the convincing sensation of "gritting" against the stone. I have found that a whalebone filiform bougie is well adapted for this purpose and more likely to be readily obtainable than the very small metal probes which would be necessary.

After local anesthesia of the vicinity of the duct, one of two methods may be used: First, a probe is inserted and the duct split back as far as may be necessary to deliver the calculus, which may require a spoon curet. Second, a direct incision may be made through the mucous membrane and into the duct at the site of the previously located stone, or into the distended duct behind the stone, or on a probe in the duct.

In the event that the stone has slipped back and cannot be found, the splitting or incision of the duct may permit of its spontaneous delivery within a few days, without further intervention.

Mathews says that one should be on the lookout for multiple stones, which were present in two of the author's cases.

Results are very satisfactory if the obstruction is found and removed, and recurrence is very rare unless a bit of calculus has been left in situ. External incisions are seldom if ever indicated, and are to be avoided.—*Jour. of the Amer. Med. Asso.*, May 22, 1920.

**A STUDY OF THE BLOOD AFTER SPLENECTOMY: WITH SPECIAL REFERENCE TO THE LEUKOCYTES.**—Hall reports the study of a series of leukocyte counts, total and differential, upon an apparently well man after removal of the spleen for injury to this organ. The convalescence was short, there was never much anemia, the counts were made daily at first but at gradually lengthening periods after the first two weeks. Unfortunately no data were obtainable prior to the accident, but the patient had been in active military service for two years; his recovery was complete and the spleen showed no abnormality other than a laceration.

The author's findings from this case can be summarized as follows: 1. The removal of the spleen resulted in a considerable increase in the total leukocyte count which persisted with much irregularity for over three months. 2. In the early period all types of white cells were increased in nearly the same proportion, although a slight increase of endothelial cells was noted at the expense of the lymphocytes. 3. In the intermediate period both total and differential counts showed such marked variation as to render averages valueless, but the total count usually was high. 4. In the final period a comparative equilibrium was reached, with a moderate increase in the total count, due entirely to lymphocytes and endothelial cells while the granular leukocytes showed strictly normal figures. 5. The endothelial cells were constantly increased both relatively and absolutely. 6. The observations on the Arneth index suggest that the increase in count is at least in part due to the removal of some factor restricting the production of white cells. 7. No eosinophilia appeared during the course of the work.—*Amer. Jour. of the Med. Sc.*, July, 1920.

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## PATHOLOGY

Conducted by JOHN G. WURTZ, M.D.

**ROENTGEN-RAY STUDIES OF BRONCHIAL FUNCTION.**—Bullowa and Gottlieb (*Amer. Jour. Med. Sc.*, July, 1920, p. 98) stimulated by X-ray evidence of a peristaltic action in the bronchi of a patient suffering from a malig-

nant tracheo-esophageal fistula, experimented with animals and after determining a suitable opaque medium, observed that the left bronchus moved laterally with each heart pulsation; that synchronous with respiration a bellows-like expansion and contraction of the trachea and bronchi is very apparent in the relaxed bronchus immediately after injection. "This expansion and compression of the bronchi is probably produced by costal breathing and the suppression of this action when movements of the ribs are limited, may have deleterious effects." They infer that the spastic contraction of the bronchus is as important in limiting the lung expansibility as it is in diminishing the calibre of the bronchi. Further, was observed a long peristaltic wave of small amplitude which seemed to be potent in the evacuation of the bronchi and trachea, and was independent of cough, respiration and swallowing. This action of the bronchial muscle seems adequate to empty the air passages without invoking ciliary movement.

PREVENTION OF SIMPLE GOITER IN MAN.—Marine and Kimball (*Arch. Int. Med.*, June, 1920, p. 661) in observations extending over a period of thirty months found that of 2,190 school children taking 2 gm. of sodium iodide twice a year (0.2 gm. for ten days), five have shown enlargement of the thyroid; while of 2,305 pupils not taking the prophylactic, 495 have shown enlargement of the gland. Of 1,182 pupils with thyroid enlargement at the first examination and who took the prophylactic treatment, 773 thyroids have decreased in size. Of 1,048 pupils with enlarged thyroids on first examination and who did not take the prophylactic, 143 have decreased in size. No case of exophthalmic goiter has developed and less than 0.5% of the pupils gave evidence of iodism and this only mild.

TOXIC JAUNDICE IN PATIENTS UNDER ANTISYPHILITIC TREATMENT.—Bailey and MacKay (*Arch. Inter. Med.*, June, 1920, p. 628) report particularly the chemical blood and urine analyses in 25 cases of toxic jaundice following antisiphilitic treatment. "In patients whose livers are damaged by arsenobenzol derivatives, an increase of cholesterol in the blood is an early and marked sign." In debilitated patients the oxidative activity of the urine is decreased. This decrease is much more marked if the liver is disordered." Further conclusions of these observers is that exercise should be greatly restricted during and for the following few weeks after antisiphilitic treatment. They suggest too, that before, during and after the administration of arsenobenzol derivatives, the diet should be rich in carbohydrates and low in protein and fat.

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## UROLOGY

Conducted by LEON T. ASHCRAFT, M.D., F.A.C.S.

A CASE OF BLASTOMYCOSIS INVOLVING THE PROSTATE AND SEMINAL VESICLES.—Parmenter and Simpson (*Jour. of Urology*, III, 449) report a case showing extensive involvement of various parts of the body. There was apparent recovery as the result of treatment. An unusual involvement of the prostate and seminal vesicles was a feature of this case. The patient, a man of forty-four, was taken with a persistent cough. His health declined, and he lost weight. Subsequently he expectorated a great deal of mucopurulent, blood-tinged sputum and had an eruption on the skin, with abscesses in the extremities, face and neck. These were drained, and treatment with



the iodides and the X-ray was given. By the fall of the third year of his illness, all evidences of the disease had disappeared. Shortly after this, the urinary trouble began. He had frequency, burning, urgency and dysuria, lasting twelve hours, after which he felt well. Three months later he had another attack of this kind, lasting a week. There was a third attack two months after this. These symptoms, although much lessened in intensity, still persist. A urological examination showed that the urine in the first and second glasses was small in amount, cloudy and tinged with blood and contained a great many prostatic shreds. Rectal examination revealed dense infiltration of the prostate, the seminal vesicles and Denonvillier's fascia, associated with a good deal of edema, and suggesting an inflammatory, rather than a malignant condition. Massage produced blood alone. Cystoscopy showed that the capacity of the bladder was only one-half normal. The mucosa seemed healthy, except for a bulbous edema around the trigone, sphincter and ureteral orifices. Clear urine was coming from the ureters. The urethra and the verumontanum appeared acutely inflamed. Later on, material showing the typical organism of blastomycosis was obtained from the prostate and seminal vesicles. X-ray treatment through the peritoneum was given, resulting in a rapid local improvement and by July, 1918, nine months after the beginning of the urethral symptoms, the parts felt normal and all the blastomycetes had disappeared. In December, however, the patient suddenly developed an acute epididymitis of the right side. This subsided at the end of two weeks, but the epididymis was left swollen and hard. Gonorrhea having been definitely ruled out, the authors believe this attack to have been a blastomycosis of the epididymis. The case is the first that the authors are aware of in which a diagnosis of blastomycosis of the prostate was made and confirmed during life, and this patient is one of the very few that have recovered from extensive systemic blastomycosis. The only infection still remaining is in the epididymis. On account of the fact that the kidney is so often affected by blastomycosis, as seen at autopsy, the authors urge a more careful study of the urinary tract.

**SARCOMA OF THE PROSTATE.**—F. C. Harrick (*Annals of Surg.*, 1920, LXXI, 168) reports a case of this condition in a man of thirty-three, who had symptoms of obstruction of the urine, ending in complete retention within two weeks. He had used a catheter for seven months, during which he had lost twenty pounds. No pain was complained of, and it was only occasionally that blood was seen in the urine. Rectal examination showed that there was a large, smooth, elastic body present. Suprapubic prostatectomy was performed, but symptoms of recurrence were noted within three months after this procedure. Radium treatment was then instituted, but without success, death occurring two months later. Autopsy revealed metastases in the liver, with double suppurative pyelonephritis.

**NEW USES OF THE SCROTUM.**—J. E. Johnson (*South. Med. Jour.*, 1920, XIII, 120) reports two cases in which he used the redundant skin of the scrotum in a novel manner. One was a case of pruritus ani, the skin for two inches and a half around the anal orifice having been scratched with the nails until it had become tough, thick and leathery, so that this entire area had to be excised. The second case was one of lymphedema of the leg following an operation for right inguinal adenitis. The author describes these two operations in which he used scrotal flaps for the repair of the lesions. The results in both instances were successful.

# THE HAHNEMANNIAN MONTHLY.

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## RENAL CALCULUS.

BY

LOUIS RENE KAUFMAN, M.D., F.A.C.S., NEW YORK.

(Lantern Slide Demonstration, Homœopathic Medical Society of the County of New York, March 11, 1920.)

THE etiology, the diagnosis and the treatment of this condition has occupied a very great deal of attention in the last few years; as a result, the whole subject has become pretty well standardized, although many problems still remain to be solved. Among these problems none is more perplexing than the origin of renal stone. The nucleus of most calculi is uric acid or calcium oxalate, the former in early life and the latter in later life—further stages consisting of these same salts or more especially of carbonate or phosphates in the presence of continued infections. It seems to be conclusively proved that the formation depends on the presence of a colloid, such as mucin or urochrome, acting as a cement substance with the crystallization of these salts from the urine, which as a biological product, it is able to hold in greater solution than can even distilled water. The old theory that the nucleus always consisted of bacteria or blood has been swept away and Cabot, although admitting the importance of infection, maintains it is of relatively little importance.

Certainly the old theory of infection, plus retention, is thoroughly disproved by careful study of cases, since, for instance, calculus is more frequent in men, although infection is almost ten times as frequent in women. In women floating kidney with inevitable kinking of the ureter and urinary retention would predispose to calculus and yet stones are rather in-

frequent in these conditions. In my own experience dilated pelvis with retention in the low calyx has not resulted in calculus. In one set of statistics the frequency of stone is given as 108 in men to 46 in women, and is said to occur a little more commonly in men in the left side and in the right side in women.

The relation of bacteria to stone formation probably involves a discussion as to whether the egg precedes the chicken—it is a question whether the infection precedes or follows the calculus. There cannot be doubt that a great many patients have urinary infections with pyelonephritis or pyelitis in whom calculus does not occur. On the other hand calculus may be demonstrated with sterile urine and after all the important question in all this discussion is the fact that the clinical course, and very largely the treatment, will be decided by the further lesions induced by the infection over the original effect of the calculus on the kidney. The recent theory advanced by Dr. Mayo that two types of infection occur by a process of symbiosis, if proved, will throw much light on this difficult problem. He advances the theory that beside the ordinary colon and pathogenic bacteria other bacteria are present which have as a function the building up of stone; he compares the formation of stone to the building of the oyster shell by the bacteria, which simply abstract the salts of the water as these special bacteria abstract the urinary salts.

It is well known that, as a rule, the colon bacilli produces an acid urine and thrives in that medium whereas the other bacteria, especially in the bladder, are likely to break up the urea and thus render the urine strongly alkaline with the consequent formation of secondary phosphate and carbonate stones. Since the colon is the most frequent infection of the kidney and presumably is always hematogenous, or at least is borne by the lymphatics, it follows that bacterial infection of this type will readily result in bacterial infarcts favored by the renal vascular system. Moreover, the kidney is abundantly able, even without lesions, to excrete all types of bacteria as a purely excretory function so that bacteria abound in the urine without calculus as well as when it is present.

It has been long recognized that heredity plays a part in the formation of stone and that it is more likely to occur in people of the so-called "gouty" tendency with disturbances of nitrogenous metabolism. The influence of climate, of race and



other factors are probably of very little importance. It is, therefore, evident from all these data that the factors which seem to favor the formation of stone are probably related to problems of metabolism, although we must recognize the extreme importance of both infection and retention. It is difficult to estimate from the old figures the importance of the etiological factor in the recurrence of stone after operation, since there is always the liability of stones having been overlooked owing to the imperfect methods of diagnosis that prevailed up to within the last fifteen years. In the more modern (1918) group of figures, Cabot states the chances of recurrence as being one in three and gives as his figures 32 recurrences out of 66 cases; other figures indicate a recurrence of 10 per cent. It cannot be emphasized too strongly that the mere presence of stone is not the important thing but that the associated damage to the kidney must determine our attitude toward the stone. This is particularly true in cases of bilateral stone and especially in cases complicated by ureteral calculus. In regard to the frequency of bilateral stone, adding to the figures of Braasch, who found 12.3 per cent. in 450 cases, the figures of Kuster and of Israel, we have frequency of 17 per cent. Kelly in his series found a solitary stone in 47 per cent. of cases and multiple stones in 44 per cent. of his cases.

These figures emphasize the liability of multiple stones in the diagnosis of which the clinical history is often most misleading. (See Case 5). In the diagnosis extreme reliance may fortunately be placed on the X-ray. In a personal communication Dr. Lewis Gregory Cole estimates the liability of error in kidney stones as being between 3 per cent. and 5 per cent., slightly under that in ureteral stones, and from 10 per cent. to 15 per cent. in vesical stones. Kelly estimates the liability of error as being 5 per cent. It is essential that the entire urinary tract be covered by an expert after thorough preparation of the patient (and of the expert) in the X-ray study and the use of the opaque catheter and especially a pyelograph and ureterograph will often be of very great assistance. It is probable that the liability of error of X-ray diagnosis is from 15 to 20 per cent. in the work of the unskilled operator or commercial X-ray laboratory. The clinical history in cases with pain, whether it be of the characteristic renal colic or of the referred variety, will often lead to the diagnosis of renal calculus, if the symptoms are carefully analyzed. It must be

remembered that frequently pain is absent over a long period; for instance, Cabot found typical pain present in 80 per cent. of his cases and atypical pain present in 67 per cent. of the cases. The Mayos report pain as present in one kidney only in 65 per cent. of their cases of bilateral stone. Hematuria is probably present in over 50 per cent. of the cases, but even in the cases in which it is absent careful microscopic search will usually find a few red blood cells. The presence of albumin in urine should always lead to a search for a calculus, if it is not accounted for readily on other grounds, since it is a frequent symptom in so-called "silent stones." The presence in the urine of uric acid, urates, or other salts is not at all an important symptom of calculus since they are found in all sorts of conditions other than stone. In this connection it is wise to bear in mind that the urine may give no evidence whatever; Cabot found a normal urine in 14 per cent. of 140 cases.

Study of the urine, skiagrams and the clinical history and examination of the patient will rarely be entirely sufficient to determine an accurate diagnosis and intelligent care of the patient. These should be supplemented by cystoscopic procedures including catheterization of the ureters with such functional tests as are appropriate, usually the Phthalein test, and the detailed study of the individual urine of each kidney, including cultures. In addition the wax-tipped catheter as well as pyelography and ureterography will assist in obscure cases. This systematic study may be arranged in the individual case so as to consume little time, and according to the indications of the particular case. Indeed, in many of these patients the cystoscope alone will demonstrate the existence or absence of an accompanying cystitis or vesical calculus, except in the very rare condition of a small diverticulum of the bladder; routine laboratory study and the X-ray are sufficient to place this class of stone cases in a group for conservative treatment.

The small stone is far more likely to cause symptoms than the large stone, which remains fixed, although the latter in the presence of infection is more likely to cause serious damage to the kidney. The small stone in the pelvis of the kidney is especially liable to cause hydronephrosis and thus give rise to marked symptoms; a small stone caught in a calyx (see Case 4), will frequently cause recurrent attacks of colic. Beside mechanical damage, a low grade inflammation is likely to result in interstitial nephritis, which is probably the cause of calculus

anuria. If infection occur, and the continued presence of the stone invites it, either pyelonephritis or pyonephrosis will occur, the latter being far more common in the so-called "coral stones," which fill the pelvis and calyces. It is not at all uncommon for patients to harbor for a long time a calculus treated under the name of lumbago and be brought to a realization of their condition by an explosive attack of renal infection.

Not only in the diagnosis but likewise in any attempted plan of treatment it is important to know the condition of the opposite kidney, even in cases of a solitary stone in one kidney. The diagnosis must, moreover, include a study of the patient as a whole, particularly with reference to the presence of cardio-renal conditions, since it is not at all unusual, especially in older patients, to have a basic nephritis to contend with. (See Case 1.)

The plan of treatment will be essentially determined after a careful diagnosis has been made by the evidence not only of the presence of a stone, but by taking into consideration all of the factors. Among these perhaps the most important is the careful history of the patient; for instance, if as so frequently happens, the patient gives a history of having passed a stone at some previous attack the chances are that a small stone may likewise be passed in the present attack. (See Case 2.) Among these factors, beside the size of a stone, is evidence of infection by purulent urine and septic temperature; an estimate of renal function not only by standard tests but what in these cases is equally important, by the clinical condition, especially drowsiness, headache, etc.; the frequency and severity of attacks and conversely the intervals of freedom of symptoms, the distribution and location of the calculus, especially with reference to bilateral or complicating calculus of the ureter or bladder.

Decision for operation will, in many cases, require the utmost judgment in order to avoid unnecessary operation and likewise to avoid irretrievable damage to the kidney by neglect of early operation in cases in which it is indicated. The medical treatment, which, of course, can have no effect whatever on the calculus, consists largely in the control of pain during an attack and, in the intervals, of regulation of the diet, bowels and manner of life to avoid concentration of urine, favor elimination and guard the patient against the danger of infection. A stone discovered in the course of routine examination,



which has caused few or no symptoms, especially of small size and locked in the cortex of the kidney, may be safely left undisturbed; but in such cases safety requires constant observation of the patient with X-ray study repeated from time to time according to the exigency of his case.

While the conservative policy may be much more safely followed in the case of ureteral calculi, the presence of calculus in the kidney requires operation, except in very few unusual cases. The operation will necessarily be largely determined by: 1st, the location of the calculus; 2nd, whether one or more calculi are present, and, 3rd, whether calculi are bilateral or multiple, as, for instance, in the kidney and ureter of the same side. There can be little question that the operation of choice for the removal of calculus is pyelotomy. In the majority of cases of stone in the cortex of the kidney, it is possible by an X-ray of good definition to actually locate the stone, using the twelfth rib, the transverse process of the first, second and third lumbar vertebrae with which to localize the calculus in the X-ray and then by just sufficient exposure of the kidney, without disturbing its relation to these bony structures, to find the calculus at the spot corresponding to the X-ray location. The possibility of overlooking other calculi can really only be guarded against by the detail of the X-ray or by some such method as that advocated by the Mayos of the direct fluoroscopy at the operating table. Extensive nephrotomy should be avoided in all cases and the ancient operation of splitting a kidney from pole to pole in the search for a small stone should be condemned. For the removal of large stones and especially for stones which can be located within the calyces, pyelotomy by either a vertical or T-shaped incision of the pelvis for necessity carried into the substance of the kidney will probably answer in all cases, except in cases in which a large coral stone with numerous branches impacted in the calyces require such destruction of the kidney as to make any other operation than nephrectomy usually unadvisable. In all clean cases the wound may be closed by a few sutures without drainage. In infected cases drainage through the pyelotomy incision permits of irrigation of the pelvis, which in these cases is usually seriously infected, although in infected cases Kelly advocates nephrotomy over pyelotomy; but since the mere drainage of a small portion of the kidney does not materially influence the infection of the rest of the organ or promote its function even in

these cases pelvic drainage would seem more logical, especially if, as often happens, the pelvis is much dilated and thickened.

There can be no question of the necessity for operation in all cases which show infection, especially in those in which the renal infection maintains continued cystitis. The use of vaccines and antiseptics, especially urotropin in large doses, should not be neglected. But even more important than the immediate infection is the probability of renal suppression, and especially acidosis, which in bilateral cases often determines the necessity for immediate operation in the midst of alarming symptoms. In unilateral calculus with pyonephrosis in which the kidney function has been entirely destroyed with compensatory hypertrophy of the opposite kidney the operation of choice is nephrectomy. In the simple cases it can be exceedingly easy but frequently is extremely difficult in cases with much associated perinephritic adhesions in which case the intracapsular nephrectomy is frequently the only operation possible.

In bilateral calculi operation should first be done on the less diseased side, or if, as in the case of Mrs. B. P., the condition is complicated by ureteral calculi, operation should be planned to restore function as rapidly as possible to the sound kidney. Operation, of course, will be contraindicated in a few cases in which there are bilateral calculi with progressive failure in renal function and marked evidences of uremia, but even in these cases a preliminary drainage will frequently restore sufficient reserve to permit of a more radical operation later on.

The mere removal of a renal calculus in cases quite free of complicating infection it will thus be seen resolves itself into a simple operation practically free of any mortality. Thus, figures of the Mayo Clinic show a mortality in all type of cases of 11 deaths in 937 cases in which 983 operations were performed or a mortality of 1.12 per cent. As compared with older statistics the mortality is almost one-third less (Watson, 135 cases, 3 deaths, mortality 2.2 per cent; Rovsing, 115 cases, 7 deaths, mortality 6.08 per cent.). In infected cases the mortality will necessarily be higher, but even in these cases it can be materially reduced not only by careful preliminary preparation and study, but likewise by careful attention to postoperative details. In the infection of the lumbar wound, which so frequently follows operation with drainage, irrigation with Dakin solution through properly placed Carel tubes, will re-

duce the septic absorption, which is such a desperate drain on the resources of a patient with urinary infection.

#### ILLUSTRATIVE CASES.

CASE 1.—Mr. C., 55 years old. Referred by Dr. W. B. House, 2/3/15. X-ray shows multiple calculi of the left kidney and a small calculus in the bladder. Cystoscopy shows a calculus about 2 cm. in diameter in the bladder; the efflux is poor on both sides; phthalein injected intravenously appears from the right side in three and the left in six minutes, with 10 per cent. recovered from the right side and a faint trace from the left in two hours. On the following day a total phthalein test revealed only 25 per cent. excretion two hours after intravenous administration. Urinalysis showed interstitial nephritis and on examination a flabby myocardium with edema of both legs and high blood pressure. The patient was, therefore, advised to follow medical treatment and to have a crushing operation for the vesical calculus, which he refused.

CASE 2.—Mr. G. B. F., 43 years of age, U. S. Salesman. 9/23/18. Twelve years ago passed a stone size of pea, round with sharp points. Seven years ago passed a second stone, oblong in shape, with bleeding, lasting a few minutes. At no other time has there been any bleeding.

Has had attacks every six weeks for fifteen years; pain shooting into right testicle from right lumbar region, with nausea. Urination is normal, but during attack of pain it occurs in the day every hour, at night, two or three times, with much tenesmus and scalding, but the urine is free of blood or pus.

An X-ray taken in California of the right kidney region was normal early in 1918; only one plate was made and none of the ureters. Cystoscopy September 10, 1918, showed merely congestion of the right ureteral meatus with normal efflux from both; the catheter was arrested at 5 cm. on the right side; specimens of urine were normal; cultures from bladder and each kidney were sterile. An X-ray taken a week later revealed a calculus of the right ureter at about the pelvic brim. February 3rd, on rectal examination during a sharp attack of the old pain, the calculus could be felt clearly in the lower end of the right ureter and palpation caused excruciating pain. It was gently manipulated and was felt suddenly to slip into the bladder, following which the patient complained of intense



pain in the bladder with tenesmus and he was at once sent to the hospital. Cystoscopy showed the calculus to be covered with many sharp spicules and, when it was made to move in the bladder occasioned intense pain. The next day it was crushed with the lithotrite and the fragments removed by irrigation through the sheath of the cystoscope.

The patient since then has remained free of symptoms. Careful urinalysis, as well as cystoscopy and complete X-ray study of the tract, reveal no abnormalities.

CASE 3.—Joseph S., 35, born Russia, married, collector by occupation, referred by Dr. Mary Friedman, October 19, 1917.

PREVIOUS HISTORY.—Family and previous history negative. For about two years had irregular attacks of pain in the back lasting several days at a time and for which he consulted a number of doctors, who assured him he had lumbago.

PRESENT ILLNESS.—On Sept. 22, 1917, while walking, was seized with sudden pain in left side of the abdomen and back, which compelled him to sit down and for which he was sent to a nearby hospital in an ambulance. There his condition was diagnosed as "renal colic;" X-ray picture showed two stones in left kidney. On October 5th an effort was made to facilitate passage of these stones by an injection of oil into the ureter. On October 8th he was taken with severe chills, and a temperature of 105 degrees, which lasted two days. Thereafter he had chills, fever and sweat with a dull heavy pain in the left groin; lost ten pounds in few days; was generally prostrated and finally went home. Consulted Dr. Friedman, who referred him to me on October 19th.

PHYSICAL EXAMINATION.—Moderate temperature, blood pressure; systolic 105, diastolic 70. Tenderness along the course of left ureter and the left kidney region. Urine cloudy. On October 22nd complete X-ray showed a calculus about the size of a small hazel-nut impacted in the lower end of the left ureter. There was a trifling amount of vesical irritation, voiding twice during the night and five times during the day. Cystoscopic examination (October 24th) showed a superficial cystitis limited to the region of the left ureter with marked eversion of the left ureteral meatus, which protruded into the bladder and which was obviously swollen. From the left ureteral outlet purulent urine passed in small quantities; the right ureteral outlet was normal with a normal, vigorous efflux of clear urine.

Catheterization of the right ureter was normal; the first effort at catheterization of the left ureter was impossible but finally by a teasing rotary to and fro introduction the catheter was guided into the outlet of the left ureter from which there was an escape of a cheesy secretion. The ureter was seen to open on the withdrawal of the catheter which was followed by the escape of a cast-like string of cheesy pus, that rolled into the bladder breaking into a cloud as it dissolved in the bladder solution. Following this there was an escape of purulent urine through the left ureter and the catheter was introduced without difficulty to the pelvis of the kidney. Functional tests showed that the right kidney excreted phthalein after intravenous injection in three minutes in a definite amount; the left kidney excreted a bare trace in twenty minutes; in one hour right kidney phthalein 35 per cent., the left kidney only a bare trace; urea 0.9 per cent. on the right and 0.15 per cent. on the left. During the time the patient was in Flower Hospital, where he was admitted on October 23rd, until operation, he ran a very slight temperature with normal pulse and respiration. Blood cultures were negative. Cultures of his urine showed coli communis.

OPERATION.—On October 29th nephrectomy was performed with the usual section of the ureter, proving to be a difficult operation owing to the presence of perinephritic adhesions; the kidney was small with marked ecchymotic discoloration of the cortex beneath the capsule, which stripped with difficulty and, on section, it was found to be characteristic of advanced pyelonephritis, having been very largely destroyed by previous inflammation. Convalescence was uneventful.

COMMENTS.—This is a case of latent renal calculus in which the calculus caused a definite attack of pain with presumably the latent infection or possibly a sterile ureteritis which became infected on efforts at mechanical removal of the calculus followed by an immediate obstruction of the ureter and a gradual destruction of the left kidney. Nephrectomy was indicated as the only logical operation in view of the presence of infection, the general condition of the patient and previous history. The result has been satisfactory; examination of the patient at the end of three months after operation showed a sterile urine, the function of the solitary kidney being entirely satisfactory with no clinical symptoms to be attributed to the presence of calculus, which presumably lies in a diverticulum





of the left ureter, where at any time it may be removed by intravesical efforts, if it gives rise to further symptoms.

CASE 4.—Mrs. C. M. Widow. 33 years of age. Referred Dr. S. B. Moore 1/6/20. Family and personal history of no bearing, except for an operation January, 1912, for removal left tube and ovary. Always well.

Two years ago sudden onset of pain in the region of the left kidney, while taking a shower at the seashore; the pain was continuous for three days, was not referred and required morphine; there were no vesical symptoms and she had no fever. A year later in the night following a slight malaise, which had lasted two days, she was seized with a sharp pain in the left renal region similar to the first attack, which required morphine; this pain was referred to the vagina, became intermittent in a day or two and was followed by a dull ache in the left side for weeks. Attacks recurred at intervals of two or three months and in an attack in September, 1919, she fainted. X-rays taken at that time showed a stone in the left kidney; she was in the hospital because of pain for three weeks and was twice cystoscoped but operation was not advised. At times she has had increased frequency but her urine has never shown gross blood nor pus. Lately she had had a dull ache in the side ever since an attack early in December, which lasted three days and required morphine. Lately she has been dizzy, at times "her feet and hands swell and she has specks before her eyes."

Cystoscopy January 6, 1920, showed a normal bladder with the right and left ureter giving a normal spurt. Phthalein test was combined with polyuria test.

Total phthalein (intravenously, January 7th) gives an excretion of 71 per cent. in two hours. The 24 hour urinalysis showed quantity 720 c.c.

Cystoscopy was repeated January 9th for catheterized kidney specimens and again January 15th for pyelography (see reports).

From a study of all of this data we arrived at the conclusion that we were dealing with a calculus in the lower calyx of the left kidney; a particularly clear skiagram showing a normal kidney outline on the right side and the pyelogram showing apparently normal ureter, pelvis and calyces on the left side. Accordingly, we advised removal of the stone.

OPERATION.—At Hahnemann Hospital, January 26, 1920,

Mrs. C. M.	Jan. 8, 1920	Feb. 21, 1920	January 9, 1920		Bladder
			Left Kidney	Right Kidney	
Quantity .....	720 c.c.				
Transparency .....	Cloudy	Cloudy			
Reaction and Color .....	increased Yellow	Weak			
	Red	Yellow			
Sediment .....	Moderate	Scanty			
Odor .....	Negative	Negative			
Specific Gravity .....	1.024	1.012			
Urea .....	2.8%	0.9%			
Total Solids .....	40.26 gms.		0.2%	0.2%	1.6%
Sodium Chloride .....	0.62%	0.52%			
Sulfuric Acid .....	0.37%	0.13%			
Phosphoric Acid .....	0.16%	0.09%			
Indican .....	Large Amount	Moderate			
Sugar .....	Negative	Negative			
Albumin .....	0.016%	Negative	Negative	Negative	Negative
Acetone .....	Negative	Trace	Negative	Negative	0.031 %
Crystals .....		Negative			
Pus corpuscles .....			Moderate	Negative	Abundant
Epithelia .....	Few Round and Columnar	Few Round and Columnar	Few Round and Columnar	Few Round and Columnar	Few Round and Columnar
Blood .....	Scanty	Negative	Negative	Negative	Present
Pus .....			Negative	Negative	Abundant
Leucocytes .....			Negative	Scanty	Negative
Cultures .....			Negative	Negative	Bacillus Coli

through a Mayo incision the kidney was rapidly delivered and was found to be a congenital infantile kidney the size of a butternut but with a normal pelvis and ureter. The stone was readily palpated in the lower pole of the small kidney. It was deemed wise, in view of the knowledge that the right kidney was performing its full function, to perform a nephrectomy, the ureter being ligated and sectioned low down. The wound was closed without drainage. The patient made an uneventful recovery and left the hospital in 14 days.

Mrs. M. Jan. 6, 1920					
Polyuria in c.c.			Phthalein (intravenously)		
Time	Right	Left	Time of Appearance	Right 3 min.	Left 4 minutes
30 min.	18	120	First ½ hour	30%	5%
15 "	20	3	25 minutes	14%	Trace
15 "	40	5			
10 "	145	22			

At end test: Bladder contents—90 c.c., 16%

ROENTGEN FINDINGS.—1/5/20, by Dr. Lewis Gregory Cole. Plates were made following the injection of bromide into the left kidney pelvis, also of the kidney tract following the evacuation of the bromide and the removal of the catheter. In the plates made prior to the injection of the bromide there is distinctly shown at the immediate tip of the catheter in the left kidney pelvis a small oblong calcification. The pyelogram shows a long fusiform dilatation in the first portion of the ureter, partial filling of a normal kidney pelvis and the outline of the upper and middle primary calyces. The lower primary calyx is not shown. Plates made following the evacuation of the bromide reveal the same oblong calcification previously shown.

ROENTGEN DIAGNOSIS.—From a study of these plates, I believe we are justified in making a positive diagnosis of a calcification which, from all the evidence presented in these plates, appears to lie in the lower primary calyx of the kidney. I believe that we are justified in making a negative diagnosis of a dilated kidney pelvis or pockets within the kidney substance. The position of the left kidney is normally higher than the right.



Mrs. L. P.	Dec. 29, 1919	Jan. 6, 1920	Jan. 16, 1920
Quantity .....		42	44
Color .....	Yellow	Yellow	Yellow
Sediment .....	Cloudy	Cloudy	Heavy
Reaction .....	Acid	Alkaline	Alkaline
Spec. Gravity .....	1.019	1.012	1.011
Albumin .....	Present	Trace	Trace
Sugar .....	None	None	None
Acetone .....		Faint	None
Diacetic Acid .....		Faint	None
Indican .....		None	None
Urea .....		6.3 gms.	2.6 gr.
Chloride .....		4.2 gms.	4.4g
Phosphate .....		10 gms.	10.5g
Total solids .....		39 g.	37.7g
Casts .....	Few	None	None
Crystals .....	Phosph and Urates	Many	Few
Pus .....	Plus	Few	Few
Blood .....	Scant	None	None
Epithelia .....	Many	Scant	Few

Blood	Dec. 29, '19.	Feb. 5, '20.	Feb. 20, '20.	March 10
Color index .....		7		Blood
Hemoglobin .....		50%	50%	urea
Red Cells .....		3,600,000	14,200,000	
Leucocytes .....	22,200	15,000	8,300	
Polys .....	93%	74%	68	16
Large lymphocytes	2%	8%	10%	
Small lymphocytes	5%	16%	22%	
Transitons .....	17%			
Basophyles .....	1%			

CASE 5.—Mrs. L. P. 45 years. Married. Referred by Dr. Charles Buckmaster, 12/29/19.

PAST HISTORY.—Constipated all her life and has frequently had no movement for five to seven days, at which time she suffers from headache and malaise. When 13 had spinal meningitis, and has always been delicate. She has six children living, all of whom are well. Menses regular for three years. In 1918, while returning from a "picnic" she was suddenly seized with a pain in left side of abdomen; on her return home she remained in bed the next day and was relieved by heat applied to the abdomen. For several years she has had increased frequency of urination—three times at night, every

one or two hours by day—and for the last week her urine has been cloudy and offensive.

PRESENT HISTORY.—On December 27, 1919, she felt a pain in the left hypochondriac region, which at first was continuous and dull, but in a few hours radiated with sharp shocks across the abdomen accompanied by vomiting; the vomiting was bilious. The abdomen was distended without rigidity and the bowels were obstinately constipated without relief by enemata. Over the telephone her doctor described the condition as typical of intestinal obstruction and she was brought to the Hahnemann Hospital for immediate operation.

On admission, December 29th, she complained of marked prostration, persistent nausea, diffuse abdominal pain more severe in the left hypochondrium, and dim vision with specks before the eyes. Temperature 100.4, pulse 104, respiration 42; blood count 22,200 leucocytes with 93 per cent. polys; urine was cloudy and offensive, showing a trace of albumin with many pus and blood cells and epithelia with abundant urates and phosphates. The abdomen was enormously distended with clearly visible peristalsis, marked gurgling and slight, diffuse rigidity of all of the abdominal muscles; tenderness was elicited only over the left costo-vertebral angle front and back. The right kidney was slightly enlarged and on deep palpation moderately sensitive; the left kidney was distinctly large and swollen. The absence of fecal vomiting three days after the onset of the supposed obstruction, with diffuse pain and clear-cut tenderness of the left renal region only with an offensive urine and increased frequency and general toxic symptoms of renal insufficiency, suggested the possibility of a kidney lesion with reflex intestinal paresis.

X-RAY FINDINGS.—An immediate X-ray showed two stones in the lower end of the left ureter, a calculus of the left kidney and a large group (26) of stones in the right kidney; bilateral lithiasis complicated by ureteral calculus.

The bowels were at once emptied by energetic measures including pituitrin; alkalization; treatment instituted for renal insufficiency, obstruction and infection.

Cystoscopy performed the following morning showed a diffuse cystitis with intense trigonitis, the efflux of both ureters being cloudy; the left ureter projected and pouted into the bladder with a highly inflamed aperture from which the efflux, however, was fairly free. The right ureter was catheter-

ized and a pyelogram made at once showed a dilated pelvis of a globular form and a perfectly free ureter on the right side; the catheter could not be made to pass into the left ureter. A total phthalein (intravenously) on January 2nd, showed 45.5 per cent. in two hours. Cultures of the urine showed staphylococci and streptococci and colon bacillus, the latter persisting. Two efforts were made to remove the ureteral calculus by the operating cystoscope without success. Preparatory treatment meanwhile had diminished the signs of renal insufficiency.

OPERATION.—Performed on January 7th, under general ether anesthesia, (Dr. F. E. Smith), on the left kidney and ureter. There was no doubt that the impacted calculi were causing hydronephrosis of the left kidney, which, it was obvious, however, was less damaged than the right with its numerous stones so that the reserve power of the left, it was reasoned, would be conserved in case a nephrectomy became necessary on the right side. Through a left rectus incision the ureteral calculi were readily located; the ureter incised and the two stones extracted with suture (catgut) of the incision and drainage; at the same time the renal calculus was extracted by freeing only the lower pole of the left kidney by a small incision into the lower calyx through the cortex and the wound drained. Leakage persisted from the ureteral wound for three weeks then ceased, but recurred from time to time; the renal wound healed in three weeks without leakage. Temperature before operation had averaged 103 each afternoon and continued septic; pain became marked in the right kidney and the urine, loaded with pus obviously draining from the right kidney, kept up cystitis with great dysuria and frequency.

On January 29th, three weeks after the first operation, the right kidney was exposed; the pelvis was found adherent to the lower pole and the ureter, which were matted by an exudate; the pelvis was globular and about 4 inches in diameter; the kidney was large, intensely congested with hemorrhagic areas beneath the capsule. Pyelotomy was selected since the pelvis was readily accessible, bulging and the stones could be felt; a T-shaped incision of its posterior wall liberated 3 ounces of purulent urine and 26 stones were removed from the pelvis and calyces, which were clearly exposed, lined by congested thickened tissue; the wall of the pelvis was leathery, ecchymotic and covered by a fibrinous exudate both within and without; the uretero-pelvic junction being unusually large. A catheter



was passed retrograde into the bladder, which was irrigated as well as the pelvis, a large rubber tube sutured in the pelvis with closure of the balance of the wound and gauze loosely packed around the kidney. Two days later the gauze was removed and the kidney wound, violently infected, was treated by the Carel Dakin technique. Irrigation was maintained for ten days through the pelvic tube by Dakin solution at the same time. There was a steady drop in the temperature and all tubes were removed in two weeks. On February 6th (eight days after operation) a blood transfusion was done. Since then the patient has slowly improved. The urine now is voided naturally, without vesical symptoms, but remains cloudy. The blood area on March 10th was 16. The patient was discharged in excellent condition March 22, 1920.

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### THE IDEALISM OF HOMŒOPATHY.

BEING THE FIFTH HAHNEMANNIAN ORATION DELIVERED BEFORE  
THE HOMŒOPATHIC MEDICAL SOCIETY OF GER-  
MANTOWN, APRIL 19, 1920.

BY

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IN using the word "idealism," I do not intend to travel into the realm of transcendental philosophy, for it is not my intention to wander too far from the practical. By the use of the word "idealism" I am thinking of an "effort to realize the highest type of anything" or of "conforming as completely as possible to a standard of perfection."

We need not trouble our minds about platonic, cartesian, or Kantian definition of the ideal. According to my own conception it is not too much to claim that ideals rule the world. These ideals may be high, or they may be low, but humanity according to its vision is everywhere striving after the ideal. The past five years have seen more idealism in the world than any preceding similar length of time. The terrible and sanguinary conflict which has just closed was a war of ideals. On the one side there was the idealism of the superman, the irresponsibility of the state, the sacrifice of individuality, and the ideal that might makes right; while on the other there was

an idealism of justice, of law, order, individual freedom, honor, liberty, co-operation, universal brotherhood, etc. Even in the present disturbed condition of humanity, in the restlessness and strivings of mankind, there is a reaching out after a something that is considered higher—an unattained ideal.

The question immediately before us is, has homœopathy any idealism, or is it simply a humdrum method of practice without special standards? Some of us have not lived long enough yet to have lost our ideals, although it is to be hoped that some of our ideals have changed with the passing of time. We certainly have not outlived the necessity for ideals, and we must strive to have our lives measure up to a high conception of efficiency and usefulness.

Let us look at homœopathy with some of these thoughts in mind. Homœopathy is a method of treating sick people. It is a specialty in pharmaco-therapeutics, but in the light of its founder it is more than this.

From what source shall we derive a knowledge of homœopathy? To whom shall we go? It would seem natural to turn to Hahnemann himself and not to his followers or critics, but it is a curious thing that many of our colleagues have obtained their ideas of homœopathy from some of Hahnemann's disciples. There have been many interpreters and expounders of homœopathic principles, from Boenninghausen to Kent. There was a gigantic British trio, Drysdale, Dudgeon, and Hughes, and in America we have had Dunham, Hempel, Allen, Hering, Lilienthal, Farrington, and many others—scholars of the first magnitude, but from the standpoint of ripe scholarship and a logical mind, Hahnemann stands out head and shoulders above the tallest of our race.

The point I wish to make is this: If we wish to know anything about homœopathy, Hahnemann certainly is the one to go to for this knowledge. In the "Lesser Writings," in the "Chronic Diseases," "Materia Medica Pura," and the "Organon" we shall find very clearly and very definitely all there is to be known about the evolution and the principles of homœopathy.

What does Hahnemann say to us, then, in answer to the question "Has homœopathy an idealism different from, or higher than that possessed by traditional medicine?" Let Hahnemann speak through the "Organon," the most unique piece of medical literature in existence.

As you know from 1810 to 1833 Hahnemann issued five editions of the "Organon," of which there have been many translations. The American editions have been exhausted, but we have to thank Dr. C. E. Wheeler, of London, for having presented us within a short time, a very readable and most satisfactory translation of the first edition which was published for Everyman's Library, and which has not yet been wholly exhausted. We are more familiar with the 5th edition, translated in England by Dr. Dudgeon, and in America by Dr. Conrad Wesselhoeft, than with the others, and the references here will be made to this 5th edition. The Wesselhoeft edition has the advantage of presenting Hahnemann's ideas in shorter sentences than the original, while not in any way departing from the sense of the letter.

We shall find on thoughtful reading that the first paragraph of the "Organon" contains an idealism that is not equalled elsewhere in medical literature. It forms the foundation upon which homœopathy itself is based. The paragraph is so simple that its idealism is not at first apparent. The paragraph reads, "The physician's highest and *only* calling is to restore health to the sick, which is called Healing." The idea, therefore, is that the physician's highest calling is to heal or to cure or to restore to health. It is *not* his highest calling to palliate. It is not the physician's first duty to please his patient. It is not the physician's highest duty to make a diagnosis, even if a clever and brilliant one. It is not to study the etiology of disease. It is not to delude himself and deceive his patient with palliation, when a real *cure* is possible. It is not his highest duty to make more calls in a day than his colleagues can make, or to see a large number of patients in a short time, or to make a reputation for himself, or to roll up a big bank account, or to excel in golf or amateur theatricals, or to be a leader in society. It means that the physician will not be content with empiricial means when he has at hand a method that is more specific. It means that he willingly and unselfishly devotes all his skill to accomplishing a real *cure*. It means that he leaves research work and original investigation to those specially trained and equipped for research work, or takes part in it as a side issue only. It means that individual pleasure and comfort, as well as social, political and other duties are to be subordinated to the one great object of *curing* his patient. In its essence this ideal purpose reaches



quite as high as does the Hippocratic oath, which, in my estimation, is the only thing in medical literature that approaches it.

The second paragraph continues the idealism in claiming that "the highest aim of healing is the speedy, gentle and permanent restitution of health in the shortest, most reliable, and safest manner." This is again reminiscent of the oath of Hippocrates, which holds that the physician should use his utmost effort "to heal without prolonging the malady."

It is well for us to ask ourselves occasionally, if we live up to this idealism. Is it our prime object, our first and most earnest thought and desire to *cure* the patient who applies to us for advice and help; to restore him to perfect health in the shortest possible time and by the safest and most reasonable means? We may find assistance in our efforts to do so by a clear comprehension of the idealism of paragraph three, which, to my mind, is one of the most significant paragraphs ever written in medicine. Hahnemann claims that in order to cure speedily, gently, and permanently in the shortest, most reliable and safest manner, it is absolutely essential that the physician should possess all attainable knowledge concerning four things:

I. He must know all that is to be known concerning diseases—"what is curable in disease in general, and in each case in particular;" and that means that the physician must know all that is to be known of etiology, bacteriology, pathology, and diagnosis including modern laboratory technique, as well as prognosis. This is not a low standard or a light requirement, and it does away wholly with the unfounded criticism which formerly was frequently made of homœopathy, that it cared not for pathology, that it considered only symptomatology.

II. The physician's knowledge must include a "perfect knowledge of medicinal power." That is, he must be thoroughly acquainted with drug action. This includes toxicology and drug pathogenesis and makes an enormous demand upon the possibilities of the human brain. This single ideal has never been reached and failures here form a very weak spot in the physician's armor.

III. The physician must know how to adapt his knowledge of drug action to what he has recognized as morbid in his patient. That is, he must possess a perfect knowledge of pharmacotherapy. Here again, is an enormous demand. A demand which is inadequately met even by the closest prescriber.

IV. Finally, in recognition of the fact that one's knowledge of disease, and his knowledge of drugs, plus his knowledge of pharmaco-therapy, is not sufficient always to cure his patient, the physician must possess the power of recognizing the *obstacles in the way of recovery and how to remove them*. It is unnecessary at this time, to bring forward illustrations, for they abound in the experience of all physicians who are engaged in general practice. It is enough to claim with Hahnemann, that it is only when the physician possesses complete knowledge of these four subjects, that he is prepared to act as a "true master" of the art of healing.

While holding to the lofty aim of cure, Hahnemann permitted himself to think of preventive medicine, as is shown in the fourth paragraph of the "Organon."

But there is something of more than passing interest in the fifth paragraph (repeated in paragraph 208) something that in Hahnemann's day at least was a very high idealism.

Recently there has been introduced into our hospital work, with loud acclaim, what is known as "social service" work, wherein the worker is supposed to be of service to the physician in throwing light upon the occult and difficult cases, by studying the social, domestic, and industrial relations of the patient. But over a century ago Hahnemann claimed that the physician in curing derives assistance from a knowledge of facts connected with the history of a case of chronic disease, more particularly the character of the patient's mind and temperament, his occupation, his mode of living and habits of life, his social and domestic relations—in short, it has taken the profession a full century to grow up to the idealism contained in this fifth paragraph of the "Organon." Industrial and vocational medicine is becoming popular at the present time, and is looked upon as a wonderful development, but one is apt to forget, or may not even know, when the seed was planted, when it took root, or how it grew.

We now come to one of the most significant ideals in the "Organon." One which certainly is not appreciated by the profession at large, and which is not fully appreciated even by Hahnemann's followers. An idealism that has to do with the nature of disease itself. Hahnemann describes disease simply as an "aberration from the state of health," and he maintains most vigorously and convincingly that disease is a nonentity, that it is intangible—impalpable—invisible—and immaterial;

that it is not a thing to be bled out, or sweated out, or purged out, or mechanically removed from the patient. Hahnemann was vehemently opposed to the materialistic doctrines of his day, and unquestionably would refuse to accept the mechanistic theory of life of our own day. One can see at a glance the effect such a conception must have upon one's practice. Instead of looking upon the end results as the disease, he considers the inner workings of the vital force which is the essential part of the individual. For instance, every physician knows that pneumonia is something more than a consolidated lung, with concomitant symptoms; that scarlet fever is something more than a red rash, sore throat and fever; that measles and smallpox are something more than characteristic eruptions; that epilepsy is more than a mere convulsion; that diabetes mellitus is more than glycosuria; that carcinoma is more than a neoplasm, and so on through the whole category of diseases.

Hahnemann claims that these symptoms of disease are simply indications of the disturbed inner life of the individual, and this is the thing to keep in mind in prescribing the curative treatment. According to Hahnemann, pain is not the disease, but only the result of the disease; colic is not the appendicitis, but only the result of this special inflammation. The most common cry of humanity, however, if pain is present, is to be relieved of the pain, not to be cured of the disease.

Hahnemann's conceptions of life, therefore, (or of disease) were in accord with the most profound thought of the ages, and he boldly approaches the age-long question of life itself, "What is life?" and applies his answer, that is his idealism, to the question of disease. He knew, as we all know, that the body is not the individual, the entity himself: that the flesh is not the essential thing. He says in paragraph 15, ". . . Although the organism as material instrument serves for the purpose of life, etc., . . ." It is universally recognized that a man may be minus an eye, or ear, or tongue, an arm, or leg, or spleen, or stomach, or gall bladder or other of the organs of the body which in these days are removed on account of some abnormality, and yet the man has not lost anything that makes his individuality, his essential self. It is known that the body is dying or going to pieces every moment that the matter of which it is composed is in itself inert, dead; that it must be vivified to be active. Blood discs, epithelial cells of the external and internal surfaces, and other cellular ele-



ments of the body are degenerating and ceasing to be active (living) every moment of time, but the man himself continues to exist as a "personality" without loss of his individual characteristics. It is widely acknowledged by scientists, philosophers, poets, by humanity generally that the body is but the residence, the habitation of the indwelling "vital force" as Hahnemann called it, or the "pneuma," the "psyche," the "archæus," the "anima" of some of his medical predecessors, or the spirit or soul of more modern writers.

As sung by the Poet Anatomist, Oliver Wendell Holmes in his famous "The Chambered Nautilus:"

"Through the deep caves of thought I hear a voice that sings:  
Build thee more stately mansions, O, my soul,  
As the swift seasons roll!  
Leave thy low-vaulted past!  
Let each new temple, nobler than the last,  
Shut thee from heaven with a dome more vast,  
Till thou at length art free,  
Leaving thine outgrown shell by life's unresting sea!"

Another, and a very unique conception of Hahnemann's, a matter really of that simple, common-sense observation that was one of his characteristics, has to do with drug action. The idea is one which has not yet permeated the thought of the medical profession and is foreign indeed to the thought of the laity. This conception or observation is that drugs are essentially pathogenic in their action: that they are sick-making, that is, that they are capable only of producing "an aberration from a state of health," which is Hahnemann's definition of disease. The physician in his efforts to cure his patient must know how to utilize this pathogenic power of drugs. According to the "Organon," paragraph 21 claims:

"It is then undeniable that the healing property of drugs is actually undiscernible in itself, and that even the purest experiments, conducted by the most acute observer, fail to reveal any peculiarities of drugs, marking them at once as medicines or healing remedies. It is possible only to recognize the power of drugs to produce distinct changes in the state of feeling of the human body, particularly of the *healthy human body*, and to excite numerous definite morbid symptoms in and about the same; and it follows that, if drugs act as curative remedies, they exercise this curative power only by virtue of their faculty

of altering bodily feelings through the production of peculiar symptoms. Consequently those morbid disturbances, called forth by drugs in the healthy body, must be accepted as the only possible revelation of their inherent curative power. Through them only we are able to discover what capacity of curing disease is possessed by each individual drug."

In paragraph 19 Hahnemann says: "... we may readily understand how impossible it would be to cure diseases by medicines unless these possessed the power of altering the state of health . . .;" and in paragraph 20 he says that this power of drugs to modify the health of man "cannot be comprehended by a mere effort of reason: it is only through manifestations of their effect upon the state of health that this curative power of drugs is experienced and distinctly observed."

The conceptions or observations here set forth were *big* indeed for Hahnemann's day and lose nothing in magnitude even in this our own day. The ideas involved should have been a death-blow to crude and unprogressive empiricism, for they lay the only foundation for pharmaco-therapy that scientifically can be laid. This instance of Hahnemann's insight has not yet been adequately recognized. It logically and directly led up to three things, which, without other accomplishment, were enough to immortalize the memory of their originator:

I. The study of drug action upon healthy humans—for short, called "provings" in the language of homœopathy.

II. The establishment of the idea that drugs are *pathogenic*, and it is this pathogenic power only that must and can be utilized therapeutically.

III. And this laid the foundation for the Science of Drug Pathogenesis, the only science upon which a pharmaco-therapeutics can be based.

With this comprehensive, logical, and reasonable conception concerning disease and drug action; with the idealism that the physician must possess all attainable knowledge, as outlined in paragraph 3 of the "Organon," Hahnemann attacks the subject of pharmaco-therapy. And it is here that he shows his sagacity and wisdom, his logical thought, his unusual power of discrimination and description, his relentless, analytical acumen, his convincing reasoning and his constructive energy. It is here also that by his keen, just, but cutting criticism of the "medicine" of his day and the therapeutics which had prevailed throughout the preceding centuries from the

dawn of medical history, that he brought upon his devoted head the abuse, the persecution and the hatred of his contemporaries.

According to Hahnemann (see "Organon," pars. 52-62) there are three principles upon which drugs may be prescribed in the treatment of the sick. These principles he describes, illustrates, criticises, condemns, extols, as the case may be, in the "Organon," its "Introduction," in his essays "Aesculapius in the Balance," and elsewhere in his writings. For the present purposes let me briefly refer to these methods as follows:

I. The Galenical principle of *contraria contrariis*—the antipathic or palliative principle. According to this method a pain is antagonized by an analgesic; a fever by a febrifuge; a cough or nervousness by a sedative; insomnia by a hypnotic; constipation by a cathartic; diarrhoea by an astringent; weakness by a tonic; acidity by an alkali, etc. This is a simplified, natural, popular and wholly irrational and ineffective way of treating sick people, if the object of the treatment is what it should be, *cure* and not mere palliation, which often actually interferes with a cure. Palliation under certain pathetic conditions may be the only possibility and the physician must be willing to avail himself of all reasonable palliative measures, but he should use them intelligently and intentionally, without deceiving himself as to his purpose.

II. Another principle, the heteropathic, or allopathic is essentially empirical in its nature and frequently has an assumed etiological factor or a pathological theory as its point of attack, its search for "specifics" having proved a disastrous failure. It has the support of antiquity, but one of its main characteristics is its mutability. In the name of progress, without apology for past inefficiency, it changes its tactics with every change of theory, or new acquisition of knowledge, and has finally reached a stage bordering on nihilism in things pharmaco-therapeutical. At the best the principle bears no pathical relationship to the condition under treatment, and in general simply adds an artificial or drug-produced condition to the existing disease thereby increasing or doubling the burden nature already is carrying. The administration of a cathartic to remove the assumed cause of headache is a familiar example. The exhibition of aspirin or of quinine to cure a "cold" is an instance of what might be called "free-hand" heteropathic prescribing.

The homœopathist is puzzled by the obstinate refusal of



the dominant, self-styled "rational" and "scientific" (allopathic) school to dispassionately investigate the claims and principles of homœopathy when the "rational" practitioner is so poverty-stricken in his pharmaco-therapeutic resources as to resort to the use of a proprietary medicine in a very large percentage of his cases. It was a "druggist" from the city of Lynn, who, testifying before a special committee of the Massachusetts State Legislature in March, 1920, said that during the influenza epidemic which created such havoc in 1918-1919, he put up over 2,000 prescriptions, 91 per cent. of which called for aspirin. Surely something of homœopathic idealism and knowledge is needed by such prescribers.

III. The third and remaining pharmaco-therapeutical principle is the homœopathic, in accordance with which a drug is administered primarily to cure conditions similar to conditions the drug itself is capable of producing when taken by healthy persons. For instance, ipecac, apomorphia or kreosotum will be prescribed for the kind of nausea and vomiting these drugs are capable of exciting in appropriate doses in healthy people. Calomel, podophyllum, aloes, etc., will be given to patients suffering from the kind of diarrhoea these drugs are able to produce. Phosphorus, antimonium tartaricum, or iodine will be exhibited in various pulmonary conditions most similar to their pathogenetic records. Arnica, colchicum, bryonia are given to those patients suffering from the complex of symptoms resembling the symptoms of myalgia or arthritis these drugs have shown themselves capable of producing in healthy people. Cimicifuga, sanguinaria, gelsemium, glonoine, etc., would each be given to cure the particular kind of headache each one can produce in the healthy.

Examples might be multiplied to the point of becoming wearisome but enough illustrations have been given to show that homœopathy has a very definite method of procedure, a guiding rule, a fixed and explicit formula, by means of which a prescription may be made with the expectation of gently reinforcing nature's reaction against a disease-producing influence, thereby hastening recovery.

Finally, in one other particular Hahnemann's practicality leads him almost into the realm of the ideal, and in this particular the medical profession as a whole is ages behind him in breadth of vision. When classifying diseases (paragraph 73 *et seq.*), he claims that the great groups of acute diseases (epi-

demic and contagious) are self-limited in nature and "if left to themselves, they will, within a limited period, terminate in recovery or death, as the case may be." That is, they are not very materially affected by drug treatment. Some conditions are so mild "a slight change of diet, and habits of living, generally suffices to remove them" (par. 150). Other cases require "psychical treatment" (par. 226); still others require removal to "a mountain region" if the difficulty originated in a marshy district (par. 238). In note 63 to 67 the necessary use of "palliatives," of "stimulants," of "antidotes" to poisoning are referred to. Some diseases are recognized as "subject to the manual skill of surgery" (par. 13) and more particularly in par. 186 may be found a list of typical conditions which "require mechanical skill" and "properly belong to surgery alone." In brief, Hahnemann makes a plea for chronic diseases and claims that it is in the great class of chronic diseases that incline neither to spontaneous cure nor to dissolution, that medicine has its great excuse for existence and opportunity to prove its worth. It is among these chronic diseases, no two of which are alike, where individual traits and characteristics are most in evidence, that homœopathy with its invariable "*similia similibus curentur*" as a guide, is able to apply its beneficent curative resources with a certainty that is not possible to either the antipathic or the heteropathic principle.

It is in this great class of cases, therefore, that tend neither to spontaneous cure nor to dissolution that medicine as a pharmaco-therapeutic procedure is to win its laurels or meet its doom in defeat. It is in this field that the physician's tact, his patience, sympathy and skill, his adaptability, his wisdom, knowledge and all around ability are tried to their utmost, and it is here that results, with a satisfactory degree of accuracy, may be attributed to the means utilized.

It is for each one of us to familiarize himself thoroughly with the whole of medicine, to be content with nothing short of the idealism of the 3rd paragraph of the "Organon," to act always with the intelligence demanded by Hahnemann and to aim in the treatment of our patients at nothing short of a real cure—a full and complete restoration to health.

**A SYMPOSIUM ON PNEUMONIA.**

PRESENTED TO THE HOMOEOPATHIC MEDICAL SOCIETY OF GERMANTOWN, DECEMBER 15, 1919, BY THE CLINICAL STAFF OF THE HAHNEMANN HOSPITAL OF PHILADELPHIA.

**I. INTRODUCTORY AND ETIOLOGY.**

BY

CLARENCE BARTLETT, M.D.

THE Symposium on Syphilis presented to this Society at its May meeting met with the approval of our members, so much so in fact that your Committee on Entertainment was requested to offer another symposium, and it was furthermore suggested that a seasonable subject be selected. Nothing is more seasonable than is pneumonia at the present time, as all clinical studies thus far made of large series of cases have shown most conclusively that fully 75 per cent. of the cases are observed during the months from January to April, inclusive. *Per contra*, its minimum of prevalence is from June to September, inclusive. This being December, the pneumonia season is about to begin.

Accepting pneumonia as our subject, a natural sequence of action led to the selection of the clinical teachers of Hahnemann College and Hospital as suitable essayists by reason of their large practical experiences, covering over 400 cases, in the wards of the institution.

Pneumonia is made a most interesting subject for our study by reason of its frequency, which is alleged to be increasing year after year. At the present time it is estimated that approximately 10 per cent. of the mortality of the country is due to this disease.

There is room for grave doubt as to the increase of the prevalence of the disease. If we institute comparisons between the number of cases of croupous pneumonia, so-called, as observed thirty years ago and the number of lobar consolidations of the present due to pneumococcic infection, that we may draw a conclusion, we are forced to admit the greater prevalence of pneumonia. Typical pneumonic fever possesses no greater incidence now than formerly. On the other hand, better examination technique has enabled us to discover pneumonic invasions of the lungs in cases which would in former years have gone to death or recovery improperly diagnosed. It so



happens that these atypical cases occurring in the alcoholic, the nephritic, and the senile, and, therefore, liable to pursue a latent course so far as rational symptoms are concerned, present a high death rate, and hence are noted in the mortality reports of the country.

Tradition, and tradition only, at one time was foundation for the belief that lobar pneumonia was seldom observed in infants and young children. True these subjects were known to be taken ill with pneumonia, but it was believed that such pulmonary diseases should be classed as examples of bronchopneumonia. Next we heard that pneumonic fever was fairly common in infancy and childhood, and today the study of large series tells us that pneumonia is observed with special frequency at the extremes of life, the number of cases observed in subjects prior to the sixth year being about equal to those encountered during the period of senescence. Mortality is likewise especially heavy at these periods, but especially so in the aged.

Exposure to cold stood for many years as the principal if not indeed the only generally accepted cause of pneumonia; but when it became recognized that very many individuals thus exposed failed to go down with the disease and that many of the so-called exposures were of a most trivial nature, it was felt that some additional agency was necessary for its production. The discovery that pneumonia is an infection appeared to invalidate the exposure theory. Then experiments upon animals demonstrated that exposure lowers the bodily resistance to such an extent as to make infection possible. It has furthermore been known for many years that there were numerous instances, especially among children and the aged in which exposure could not have played any possible part in the production of the illness.

Traumatism is a rare but well attested determining cause. An injury of the chest, generally a blow, causes a slight alteration in the pulmonary parenchyma, and in this the pneumococcus finds lodgment. It has been asserted that cases of traumatic pneumonia show a relatively greater amount of blood in the sputum than do those originating spontaneously. Traumatic cases present a variety of anatomic conditions. In some the distribution of the inflammation is characteristic and lobar; in others the changes are limited and are associated with but little rise of temperature, indefinite symptoms and physical signs.

There are also cases which are strictly broncho-pneumonic. It is only the lobar cases that need cause us any anxiety. In one such case carefully studied in the wards and followed up by X-ray examinations, the illness pursued the usual course. The initial or tentative diagnosis made was traumatic pleurisy because during the first day's stay of the patient in hospital, pleuritic friction sounds constituted the single physical sign.

Climate exerts comparatively little influence in the production of pneumonia, as it is a common disease the world over. It is stated, however, to be less frequently observed at the equator and in the arctic regions than elsewhere. But little can be said, though much has been written, concerning meteorological influences productive of the disease. It may be interesting to theorize on this subject, but it is not profitable.

Sex, race, occupation and environment play an etiological role only so far as they influence opportunities for infection.

No state of health protects from pneumonia, as it may attack very robust subjects. It has a special predisposition, however, for those suffering from various debilitating influences and in particular for those addicted to alcoholic excesses. Much of the incidence of pneumonia among the notoriously intemperate is probably dependent upon the exposure to which such individuals subject themselves while intoxicated. Individuals of obese build, who habitually eat too much, exercise too little, and who are more or less victimized with cardio-vascular disease, the frankly nephritic and arterio-sclerotic subjects, are especially predisposed to infection. In them also the disease is more liable to follow a fatal course.

The above remarks apply to the predisposing or associated causes of pneumonia, for after all the sole determining or exciting cause is the infection by the pneumococcus. Long before the discovery of the pneumococcus, there existed a strong suspicion that pneumonia might be an infectious disease. This suspicion had been awakened by reason of the occurrence of the disease in epidemic form from time to time. It was furthermore observed that following the example of other acute infectious diseases, each epidemic was stamped by its own individuality. Some were characteristically mild; others were remarkable for their fatality. Some were noted for the prevalence of some particular symptom, as diarrhoea; some by their disposition to attack only a certain class of persons in the community invaded. We note at the present day, seasons

during which pneumonia is especially prevalent, and we are wanting in data for the proper explanation by reason of seasonal or meteorological conditions. Nothing satisfies the problem excepting the carrying of infection. Numerous instances have also been reported in which pneumonia has invaded a number of persons in the same household. This has led to the suggestion that there may not have been direct infection from person to person, but rather that in some instances at least, there existed a house infection. It is alleged that certain dark dwellings have favored the production of pneumonia. This is entirely reasonable, because dampness and absence of good ventilation and sunlight favor the viability of the pneumococcus.

A consideration of the biological and other characteristics of the pneumococcus is hardly applicable to an occasion like the present. We are, however, interested in certain clinical questions. We know that the pneumococcus is highly pathogenic to man, causing nearly all the lobar pneumonias as well as many of the other forms. It may also produce pleurisy, meningitis, arthritis, endocarditis, etc. In susceptible animals, notably white mice and rabbits, a fatal septicaemic (pneumococcaemia) is readily established. In a few well attested examples, fatal pneumococcaemia has occurred in human subjects, death taking place from the toxæmia ere time had been allowed for the appearance of distinctive physical signs.

The virulence of the pneumococcus varies with the type, and with particular strains of these individual types. Thus we have all gradations from the supposedly harmless pneumococcus found in the mouths of a large proportion of healthy subjects, and those of the opposite extreme, capable of producing a rapidly fatal endocarditis.

The pneumococcus then may be found in the mouths of apparently healthy individuals, and it is generally assumed and has been confirmed by experiments in a number of instances, that they are of a low grade of virulence. In others their failure to produce disease in their hosts has been attributed to a high degree of immunity possessed by such individuals. Clinical observation attests the fact that with the progress of the pneumonia seasons the virulence of these mouth cocci increases so that those which in the beginning were innocent, ultimately became pathogenic. It has been noted, furthermore, that the pneumococcus increases in virulence in passing through individ-



uals. Thus one person goes down with the disease. Of those exposed only one takes the disease. The second strain of microorganisms is capable of infecting some of those who have been previously immune, and thus pneumonia may go through an entire household.

Returning to the frequency of pneumococci in the presumably healthy, Netter found them in 20 per cent. of the subjects examined; and the New York Pneumonia Commission demonstrated their presence in from 40 to 85 per cent. of all healthy individuals.

Outside of the human body, it is most viable in moist sputum, especially if not exposed to direct sunlight. Even then it does not survive longer than two weeks. When dried and exposed to sunlight, it dies within an hour. Under conditions existing in the sick room, it succumbs within an hour and a half.

For many years it has been the custom of the medical profession to congratulate itself on the then existing progress of medicine; and yet the progression of time has shown each period making great improvements over its predecessors. It is our custom just now to express satisfaction at the remarkable discoveries of the workers in the Rockefeller Institute and elsewhere. We talk almost as if the last word on etiology of pneumonia has been said. If we are wise, we should be much more conservative than we are. It is much better for us to assume that we are ever at the threshold of things still better than we already possess. Within the year Bloomfield, of Baltimore, has demonstrated the readiness with which the normal mucous membrane of the mouth and upper air passages resists the invasion of microorganisms. We have long surmised this fact; but its scientific confirmation was lacking until Bloomfield made his investigations. Resistance to infection may then be due as much to the anatomic and constitutional resistance power of the individual as to the virulence of the organism.

There are certain conditions that exist for which we have no adequate explanations. In a paper of "Syphilis a Medical Disease," I directed attention to the fact that mortality in a series of patients with positive Wassermann was surprisingly low. This fact was still further discussed affirmatively by Dr. Golden at our Pittsburgh meeting, two years ago. Swift, working at the Rockefeller Institute, prior to the war, dis-

covered that the Wassermann reaction sometimes developed in the course of pneumonia occurring in non-syphilitic patients. While he accumulated a large amount of material, the outbreak of the war prevented him from collecting his data and presenting a suitable analysis of the facts observed.

We unquestionably do know considerable of the etiology of pneumonia, but after all we are forced to admit that we have only reached the threshold of real wisdom.

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## THE SYMPTOMOLOGY AND CLINICAL COURSE OF LOBAR PNEUMONIA.

BY

G. HARLAN WELLS, M.D.

LOBAR pneumonia in its typical form in a previously healthy adult follows an almost stereotyped course, and the doctor, who, as our patients so often tell us, "just looks at me and tells me what is the matter," usually guesses correctly in this type of cases.

The chill, followed by an abrupt rise of temperature and a rapid respiratory rate, the racking cough, accompanied by pain in the chest, and by the expectoration of a scanty, gelatinous, rusty-colored sputum, furnish such a distinctive picture that "he who runs may read," and even the merest tyro in medicine would scarcely fail to recognize "the Captain of the men of death."

Following this characteristic onset, the disease progresses along well defined lines so familiar to us all, terminating, in favorable cases, with almost clock-like regularity in a crisis between the seventh and ninth day.

Were all pneumonias of this type there would be little more to be said, but, unfortunately, such is not the case. A study of any large series of cases of pneumonia reveals the fact that atypical forms occur with considerable frequency and call for careful and accurate study before a correct diagnosis can be made.

While it is naturally impossible to present in a short paper any exhaustive consideration of all the variations we meet with in lobar pneumonia, there are certain classes that occur with such frequency as to deserve special mention.

## I. ASTHENIC OR SENILE PNEUMONIA.

This type of pneumonia is very common in old people and in persons debilitated by chronic diseases.

The manner of onset is insidious, frequently without cough and without fever. The patient may complain of nothing except marked weakness, which is usually progressive and frequently accompanied by dryness of the tongue, rapid pulse, and usually some increase in the respiratory rate.

Unless the physician is on the alert and makes a careful examination of the chest, the true nature of the disorder may be entirely overlooked. It is particularly necessary to examine the posterior portion of the chest, as in the majority of these cases we find one or both of the lower lobes involved.

As a rule, the physical signs of consolidation are quite marked, and the physician will frequently be surprised to observe the marked contrast between the extent of the consolidation and the apparent absence of the typical clinical symptoms of pneumonia.

Auscultatory signs are not so pronounced, tubular breathing being frequently absent and in its place we may find a very feeble respiratory murmur. Rales are usually detected on deep inspiration or when the patient makes an effort to cough.

In a small percentage of cases even the physical signs may be very slow in appearing, and not infrequently the real nature of the condition is only revealed by a postmortem examination.

In the majority of instances the disease terminates fatally. When recovery takes place it is usually after a slow and tedious convalescence.

## 2. TERMINAL PNEUMONIA.

This condition, as the name indicates, is usually the closing scene in the life of a patient who has been suffering with cardio-vascular, renal or other serious chronic disease. The symptoms of the pneumonia may be so masked by the symptoms of the primary disorder that its existence is not suspected until death is near at hand.

When, during the course of such debilitating maladies as Bright's disease and chronic cardio-vascular disease, we find the patient exhibiting symptoms of toxemia as evidenced by a dry tongue and tendency to delirium, and we observe a tendency for the temperature to be elevated and the respiratory



rate to be increasing, we should suspect the onset of a terminal pneumonia.

A physical examination should, of course, be carefully made, and in a large proportion of cases will reveal the evidences of consolidation or of moist rales in the affected area.

The difficulty attendant upon making a diagnosis of these cases is aided by the fact that a passive congestion of the lung frequently precedes the onset of the pneumonia, and the line of demarcation between the two conditions is difficult to determine. From the patient's standpoint, however, this makes but little difference, as these cases are invariably fatal, and the distinction is of more scientific than of practical importance.

### 3. ABORTIVE PNEUMONIA.

Every physician of wide experience can recall patients whose illness has started in with all of the typical clinical symptoms of pneumonia and terminated favorably by a crisis within two or three days.

It is the custom of many medical men to say that these are cases in which the physician made a mistake in diagnosis, but there is abundant evidence to prove that genuine cases of lobar pneumonia may come to a favorable termination by crisis within such a brief period of time.

The physical signs in such cases are naturally few, and consist chiefly in increased respiratory rate, possibly some dullness and crepitant rales.

Owing to the brief time that elapses, it is rare to find in such cases the evidences of extensive consolidation of the lung, but this does not disprove the diagnosis, as typical blood findings, including the culture of the pneumococcus from the blood, have been demonstrated in these cases.

I am inclined to the view that not infrequently cases of true lobar pneumonia can be aborted in this manner by the indicated homœopathic remedy if the patient is seen shortly after the onset of the chill and fever.

### 4. CENTRAL PNEUMONIA.

This may be described briefly as the pneumonia of clinical symptoms without physical signs, and in this respect it stands in marked contrast to the so-called aesthenic or senile pneumonia.

The onset of these cases is usually abrupt with the typical

chill, cough, fever, etc., and the doctor rightly concludes that he is dealing with a case of pneumonia.

A physical examination of the chest, much to his surprise, reveals nothing, and although the disease runs its regular course, the physical signs may not appear until after the crisis has occurred.

For a long time the nature of these cases was baffling, but studies on the postmortem table, and, more recently, the use of the X-ray, have revealed the fact that the pneumonic consolidation begins about the root of the lung, and the physical signs are obscured by the normal lung tissue lying over the affected area.

By means of a blood culture, and the examination of the chest by the X-ray, we are now able to recognize practically all cases of this type.

##### 5. POST-OPERATIVE PNEUMONIA.

This condition, which is responsible for not a few fatalities following operative procedures, has been the source of much discussion.

It is certainly true that some cases can be explained by the fact that the pneumonic infection had occurred prior to the time of operation, and the surgeon who was unfortunate enough to operate at this inopportune time usually has to take the blame for a serious and not infrequently fatal complication.

This emphasizes the importance of a careful physical examination of the chest prior to operation, particularly during the winter season.

The exact manner in which infection takes place in post-operative pneumonia is still a matter of dispute. The most recent opinion, however, seems to be that infection takes place by way of the air passages, and that the irritating effect of the ether upon the bronchial mucous membrane, the chilling of the patient by exposure of the body, and the aspiration of mucous and blood from the upper respiratory tract are all factors of importance in the production of this type of pneumonia.

In some instances the pneumonic process is undoubtedly of a septic type, the result of a hematogenous infection from the primary septic focus.

The majority of post-operative pneumonias are of the

broncho-pneumonic type, but occasionally we meet with the typical lobar form.

Did time permit it would be of interest to describe the peculiarities of pneumonia in childhood; the very interesting types of pneumonia known as migratory pneumonia, apical pneumonia, the pneumonia of alcoholics, etc., but to do so would prolong this paper unnecessarily.

Before closing, however, I should like to refer briefly to some of the more important complications that follow after the active stage of pneumonia has subsided.

The most frequent of these is empyema, a condition which is the most common cause for a secondary rise of fever after the primary attack has subsided. Careful statistics would seem to indicate that this complication occurred in about 3 per cent. of cases, although in some epidemics the percentage of empyemas would run much higher than this.

I am convinced that empyema is a condition which is frequently overlooked, and it has been my custom to urge upon medical students the importance of a diagnostic puncture as the one positive means of assuring oneself of the absence of a purulent pleural effusion in all cases where the symptoms are at all suspicious.

Abscess of the lung and gangrene of the lung, while much less common than empyema, should always be borne in mind as possible causes of a secondary rise of fever when empyema has been excluded.

Pulmonary tuberculosis is a remarkably rare sequela of pneumonia, provided the patient has been free from a tubercular infection prior to the onset of the attack.

In closing, permit me to remind you that bacteriological examinations of the blood have shown that a pneumococcic bacteremia may exist with many of the constitutional symptoms of pneumonia without the development of any local lesions in the lungs.

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### PHYSICAL SIGNS OF LOBAR PNEUMONIA.

BY

WILLIAM RENDELL WILLIAMS, M.D.

THE physical signs of lobar pneumonia may be conveniently divided for brief discussion into those of the first, second and third stages of the disease. Let us then consider



the physical signs of the first stage of a frank case. The onset has immediately suggested the possibility of pneumonia to the medical attendant. If he be conservative, and not of that class that invariably diagnoses the gravest of diseases and promptly aborts them in incredibly short time, he will wish to confirm his suspicions by definite findings.

The physical signs of the first twenty-four hours are not always striking and easy to read. Indeed, the tentative diagnosis may be difficult to confirm at this early stage, where the lobe is not consolidated, but in a state of congestion or engorgement.

It is true that the pleuritic pain has probably indicated the location of the trouble if a lower lobe is to be involved. But if an upper lobe is the site of the trouble, pleuritic pain is not a feature; or if the consolidation starts deep in the lobe, not adjacent to the pleura, pain may be delayed until the second or third day, until the pneumonic process has reached the surface and the overlying pleura.

In the first twenty-four hours, inspection and percussion are by far the most valuable means of investigation.

The critical eye first appreciates the flushed and anxious face, and with the chest bared, looks for an increase in the respiratory rate. It is safe to say that if there is no acceleration of the respiratory rate, any acute pulmonary disease may be ruled out. In pneumonia, the rate is increased from the first, although at this stage there is by no means the rapid and labored respiration of the fully developed process.

If an accompanying pleurisy is present, the limited motion at one or the other base will be noted, due to the protective spasm of the intercostal muscles. Cardiac pulsation is more evident than normal, and the pulse is distinctly accelerated.

Palpation may confirm the limited mobility, but increased tactile fremitus characteristic of consolidation, is not yet present.

Percussion, I am certain, is of the utmost value at this stage. Indeed, in all chest work, skilful percussion, acquired as it is only as the result of long and intelligent application, is the most valuable means of investigation that we have.

Over the involved lobe at this stage, the note is that of dull tympany, not frank dullness nor flatness. This tympanitic note is explained by the fact that the lung is engorged and

stiff but air containing exudate has not, as yet, filled the air vesicles and bronchioles.

Auscultation at this stage, presents two striking features. First, the crepitant rales. That burst of fine crackles heard at the end of inspiration, presumably due to the stretching of the stiffened alveoli, into which the characteristic exudate is beginning to be apparent.

Second—The comparative silence over the involved lobe. This is the most striking feature of this stage. Breath sounds are very faint and distant, in marked comparison with the breath sounds over the other uninvolved lobes, which show vesicular breathing of greatly increased intensity. No doubt much of this silence is due to the splinting of the lung by the fixed diaphragm and intercostal muscles, in an effort to minimize the pain, when a lower lobe is involved. For the adjacent muscles endeavor to immobilize the inflamed pleura and lung, just as the abdominal muscles react in the case of an inflamed appendix. However, listening from hour to hour over the involved lobe, it is interesting to hear the very faint vesicular breathing develop the whiffing expiration of the broncho-vesicular type, and then merge into tubular breathing, at first faint and distant, later loud, intense and close to the chest piece.

The spoken and whispered voice go through a similar transformation. At first but slightly increased in intensity, they show, as consolidation develops, increasing intensity and nearness.

During this first stage of pneumonia, if the lungs have been the seat of a generalized bronchitis, it is interesting to see the mucous rales characteristic of that condition, disappear throughout the lobe. This was particularly marked in those cases of influenza that developed a lobar pneumonia.

In the second stage, the stage of consolidation, the physical signs of a typical case are striking, characteristic and easy to find and interpret.

The flushed face, the evident toxemia, the herpes labialis, the dyspnoea, the expiratory grunt, the racking cough, the bloody sputum, and the pulse-temperature-respiration ratio make the diagnosis easy by inspection alone. Nevertheless, a careful appraisal of the state of the lungs, heart and pleura is necessary at frequent intervals.

Palpation will show over the involved lobe or lobes, in-

creased tactile fremitus, probably decreased expansibility, and possibly a palpable pleural friction.

Percussion will give a dull note, not flat, over the consolidation, with an increased sense of resistance. Over the adjacent lung, and particularly over the upper or middle lobe, when the underlying lower lobe is involved, one may elicit a characteristic dull tympanitic note. I have frequently demonstrated this in my clinic, showing that one can anticipate consolidation of a lower lobe, which lies almost entirely posterior, by percussing the front of the chest without disturbing the patient by rolling him over. This is manifestly of value where one is dealing with a critically ill patient.

Auscultation over the involved lobe shows tubular breathing, exquisite transmission of the whispered voice sharply limited to the lobe involved, and if there are rales present in the consolidated area, they will have that peculiar echoing quality which marks them as consonating rales.

Over the uninvolved lobes, exaggerated vesicular breathing is the rule, with mucous rales if a collateral bronchitis is present; the base of the uninvolved lung should be watched for moist rales which may be the first indication of impending heart failure.

It is important to examine the entire chest at frequent intervals. The signs of upper lobe involvement are often first detected high up in the axilla. Only by frequent examination can one detect extension of the pneumonic process to other than the original lobe. It is not uncommon for the process to migrate from one lobe to another until three or more lobes are involved.

After the crisis, the third stage, that of resolution or convalescence, is entered. It is just as important to be familiar with and keep track of the signs of resolution, as with those of the fully developed process, for it is only in this way that one can detect and fully appreciate the many post-pneumonic complications that may arise.

After the temperature finally drops, the physical signs of consolidation persist for a varying length of time. As the exudate is absorbed and expectorated, the dullness gradually decreases, although it may be weeks before the lobe regains its normal resonance. Auscultatory findings keep pace. At first there is a return of the rales, moist and non-consonating (crepitus redux). These gradually disappear. The tubular



breathing becomes broncho-vesicular, and after many days, the respiratory murmur and voice transmission become normal.

So much for the physical signs of a case of normal lobar pneumonia. Bearing always in mind that pneumonic fever is a systemic disease, and the lung manifestations, in a sense, merely incidental thereto, one can explain those cases in which the victim is overwhelmed by the intensity of a virulent infection before the physical signs in the lungs become manifest.

In those so-called cases of central pneumonia, it is not uncommon to have physical signs delayed until the fourth or fifth day, to be only certainly detected just before the crisis.

In the larval or aborted type, where the whole process with the crisis, is over in twenty-four or forty-eight hours, physical signs may never be present. I saw a number of such attacks in a lad who had had ten frank attacks of lobar pneumonia, and who was eventually cured with an autogenous vaccine. For a year or more after the last attack, he would occasionally start in with all the phenomena of a beginning pneumonia, only to have the whole process disappear in a few hours.

Occasionally during the course of a pneumonia, the main bronchus leading to the involved lobe becomes blocked with exudate. Voice sounds and respiratory murmurs immediately disappear and the condition may be mistaken for a pleural effusion, or an empyema.

Frequently, however, the diagnosis is not made and not suspected because of some atypical features in the clinical course. For instance, in an alcoholic, the mental phenomena may dominate the picture. In some cases there is little toxemia, possibly no cough, and the condition is not suspected. In children, gastro-enteric phenomena, which commonly mark the onset of the disease, may entirely engage the attention of the medical attendant. Not infrequently in children, when the right lower lobe is involved, the pain, tenderness and rigidity referred to the abdomen, leads to the unfortunate decision to operate for appendicitis because the possibility of pneumonia has not been considered.

Terminal pneumonia appearing during the course of exhausting diseases, is commonly overlooked.

However, all such cases fail to be diagnosed because of not looking, rather than not knowing.

Occasionally, in cases of intense pleuritis, it is difficult

for a time to determine whether a pneumonic process underlies the pleurisy. Here one must take into consideration the degree of toxemia, the leucocyte count, the respiratory rate, and fever, which are never so high in an uncomplicated pleurisy. The sputum, if blood streaked, indicates involvement of the lung parenchyma, regardless of the physical examination, which may show only dullness and diminished breath sounds.

Pleurisy with serous effusion should offer no serious difficulty in making a differential diagnosis. The area of dullness does not correspond with one of the lobes of the lung. The patient is not so toxic, there is no leucocytosis. The heart is displaced according to the location of the fluid. This never occurs in an uncomplicated pneumonia. And, finally, needling will demonstrate serum.

The thoracic complications of pneumonia which depend almost entirely upon their physical signs for recognition, are not within the scope of this paper.

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### **PNEUMONIA: DIAGNOSIS AND PROGNOSIS.**

BY

G. MORRIS GOLDEN, M.D., PHILADELPHIA, PA.

THE diagnosis of any disease depends upon a thorough knowledge of the causative factors, typical picture, the clinical course with its varied manifestations and the possible complications. These factors are especially noteworthy in the diagnosis of pneumonia.

In considering pneumonia in a frank case, the diagnosis is usually easy and will rarely be confounded with any other disease.

It is so often that we see the atypical case or the disease during advanced stages that a perfect or frank picture is not present, hence we cannot make a direct diagnosis and must depend upon a study of the previous clinical manifestations in order to arrive at a conclusion.

One of the prime and essential factors for a diagnosis is a painstaking, logical history of the case. This should include the clinical factors, enumerated in their chronological order. This data should pertain strictly to the clinical manifestations and symptoms and not be a collection of modalities of symptoms which have little diagnostic value.

Many times such a history of a case of pneumonia, is all that is necessary and the corroborative evidence, that is physical signs, and laboratory methods simply complete the picture.

To illustrate. A case presents the following history:

A sudden onset with chill, rapid rise in temperature, pain in the chest, cough, rusty sputum, flushed face, a disturbed pulse and respiration ratio and the presence of herpes labialis would be sufficient to make a diagnosis of pneumonic fever, without further investigation.

Unfortunately it is the atypical we encounter more frequently than the typical. It must be remembered that pneumonic fever is a disease of many manifestations presenting varied and abnormal types. These abnormal types are found in the young and aged, during the course of chronic disease, in alcoholics, nephritics and also during the course of the acute infectious diseases.

In relation to the disease as occurring in aged subjects. In this type the physical signs are extremely unreliable and often wanting and the importance of a careful clinical history is a prime factor in the diagnosis. In such cases the factors in the history that are of importance consist of a bronchitis, of gradually increasing severity, accompanied by prostration, with little or no temperature, dyspnoea, plus evidence of a failing heart.

In considering the early diagnosis of pneumonic fever, the symptoms may be divided into two classes. These consist as follows:

1. Chest pain, cough and chill, which will comprise about 60 per cent. of the cases, while class 2, evidences gastro-enteric symptoms, consisting notably of abdominal pain, vomiting, diarrhoea, at times simulating appendicitis, or peritonitis. This type will total from 15 per cent. to 20 per cent., the remaining 20 per cent. will have an atypical onset. As a rule the gastro-intestinal or abdominal type of onset is associated with distinct disturbed respiration and in the advent of such a symptom, a careful examination should be made of the chest. Yet it is not uncommon to find apparently a normal respiratory rate, as the writer has frequently observed.

A diagnostic factor which has been emphasized in the differentiation between pneumonia and acute abdominal dis-



ease is the following: That in a pneumonic process we do not have a marked rigidity of the abdominal muscles. This does not hold true as in more than one instance, and only a short time ago, such a case came under my observation, in which the history revealed a boardlike rigidity of the left rectus muscle in which future events showed a distinct pneumonic process of the lower left lobe. This case was supposed to have been a perforating gastric ulcer.

An interesting type is that found in conjunction with the chronic diseases. This is a common condition and often overlooked due to the fact that the primary condition overshadows the symptoms and physical signs. The presence of temperature and cough during the course of any chronic disease should call for a careful examination of the chest for it is a well-known fact that pneumonia is a potent factor producing death in many of the chronic diseases and forms that large class known as terminal pneumonias.

During the course of acute infections, pneumonia is frequently overlooked due to the fact that physical signs are obscure and often suggest hypostasis, oedema, and infarct of the lung, when in reality a pneumonic process exists. With the aid of daily examination and laboratory findings a diagnosis can often be made.

In alcoholics the findings frequently are atypical, the symptoms being masked, but the presence of delirium, accompanied by a febrile state, without other cause, should warrant an examination as regards the presence of a pneumonia.

It is in the extremes of life that the atypical picture of disease presents itself and for that reason pneumonic processes are apt to be overlooked in both the young and aged.

In considering the differential diagnosis, those conditions which most closely resemble pneumonia and from which it must be recognized are those of acute pneumonic phthisis, hemorrhagic infarct, pulmonary oedema, bronchial pneumonia, pleural effusion, meningitis and enteric fever.

A word in relation to laboratory findings. These are only of value when considered conjointly with clinical manifestations and physical signs. Probably the most important is that of leucocytosis. It is present in varying degrees, a count of over 10,000 may be looked upon as pathological, but frequently a count below this number may be found, in fact it may

be normal and yet a pneumonia be present, which is seen in the influenza type of the disease.

A blood culture is of decidedly greater importance than a leucocytosis and a positive one shows the presence of a pneumococcoemia, although a localized lung lesion may not be present.

Of the physical signs it may be said that they are of little value during the first 48 hours, and one must not look for distinct evidence of consolidation as revealed by dullness, bronchial breathing and increased vocal resonance, but must depend upon the earlier physical signs that may be stated as follows:

1—Slight tympanitic resonance to percussion over the affected area. 2—Suppressed or diminished respiratory murmur. 3—Exaggerated or puerile breathing with hyperresonance upon the unaffected side or contiguous lobes upon the affected side with possibility of a few crepitant rales, will complete the picture. In fact the physical signs may be very late in appearing and not occur until after the crisis, as has been observed in children at times.

#### “PROGNOSIS.”

Pneumonia from a prognostic standpoint is an extremely fatal disease, the mortality ranging from 5 per cent. to 10 per cent. in private practice to anywhere from 25 per cent. to 50 per cent. or 60 per cent. in hospital work.

Statements are made from time to time by enthusiastic observers of a low mortality rate under certain methods of treatment. As a rule insufficient evidence and detail are lacking in the cases dealt with.

An important factor in prognosis is that of the degree of toxemia, for often the patient is overwhelmed by the poison, rather than by the extent and size of the local lesion. It is in this type that the general condition and powers of resistance of the individual play an important part. A high mortality rate is common among the aged and those suffering from chronic diseases, in fact the death rate in this type would be decidedly higher if all such cases were recognized, for it must be acknowledged that many are found only at autopsy, there being insufficient evidence during life.

An important factor bearing upon prognosis in the in-

dividual case is that of age. It has been stated that  $4\frac{1}{2}$  out of every 6 people over 60 years of age succumb to pneumonia. Yet remarkable recoveries do occur in the aged. In those habitually given to drink, subjects of gout, emphysematous conditions, obesity and pregnancy, the disease is especially dangerous.

Much has been said in relation to the pulse temperature and respiration ratio, as a prognostic factor; considered separately they have little value, when taken collectively they have some significance.

In a study of over 200 cases that evidenced a pulse rate of 120; respiration of 40; and a temperature of 103 degrees or more during the first 48 hours, 57 per cent. succumbed. The presence of a diffuse bronchitis associated with a pneumonia presents an unfavorable outlook, many of these cases in older subjects and past middle life, are associated with a chronic nephritis. In the Migratory type of the disease, in which there is a gradual involvement of the lung from base to apex, an unfavorable outlook is the rule. A factor upon which the writer has placed considerable confidence in a prognostic way is the relation of systolic blood pressure to pulse rate. It has been found that when the systolic blood pressure expressed in M. M. of mercury falls below the pulse rate expressed in beats per minute, such cases evidence a mortality of 70 per cent.

A study of this ratio is of great value in determining when to stimulate, how much to stimulate, and whether we are obtaining favorable results. A further factor in blood pressure study is that of the pulse pressure.

A pulse pressure of 70 or more suggests evidence of vasomotor paresis and an unfavorable outlook.

The extent of lung involvement may be of some value in prognosis. It can be stated the mortality rises in direct proportion to the number of lobes involved, but a peculiar fact is that involvement of two lobes on one side will evidence a mortality, almost 50 per cent. lower than if we have two lobes involved in a bilateral fashion.

A leucocytosis of 30,000 or more during the first 48 hours argues for a favorable outlook, although the case may be a very severe one. A polyuria which persists throughout the course of the disease may be looked upon as a favorable factor.



As a rule the presence of complications and intercurrent disease tends to make the prognosis more grave. A peculiar factor was observed, as the result of a study of 40 cases in which there was distinct evidence of syphilis and a positive Wassermann present. The death rate totaled only 17.5 per cent. These cases were all of a severe type and each evidenced complications of a high degree in which the average death rate should have varied from 50 to 75 per cent. Hence the presence of syphilis appears to have a favorable effect upon the course of the pneumonic process, lowering the mortality considerably.

In closing, let me state the prognosis of pneumonia is not an easy matter. Many cases in which we see no reason why a fatal termination should take place, it does occur, while in other subjects, with chronic diseases and other factors arguing for a fatal termination, they pass through the disease with little or no difficulty.

We cannot lay down any hard or fast rules by which to prognosticate, or any one of several rules, but a prognosis can only be made upon a careful survey of the case. The fact is that pneumonia is a localized disease, plus a toxemia, and that the outlook depends upon the patient's power of resistance, and to what extent the vital organs may meet the demands made upon them, notably those of the cardio-vascular and renal systems.

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### PNEUMONIA: TREATMENT.

BY

O. H. PAXSON, M.D.

ACCORDING to Dr. Bartlett's invitation, I am to take the part of treatment in a symposium on the disease, pneumonia. Wishing to be exact in doing my part, I referred the matter to Noah Webster. He has defined the word, symposium, as a drinking party, a drinking together, a merry feast. My expectations, and I should think the expectations of all of us, are and will be along the same line. These preliminary dry remarks are but to whet your thirst for what is to follow, knowing Dr. Bartlett as we do.

Pneumonia, pneumonic fever, and lung fever, is a disease

I presume to be as old as man. Indeed, the first case may have been that of Adam, with Empyema—as we all know he had a rib resected. It is evident from the papers which you have just heard read that there is no mystery about this disease. From its beginning to its end, in either recovery or death, I doubt whether a word can be added. Yet with all this wonderful knowledge at our command, it stands before us a disease unconquered. Not one of you sitting here tonight but will acknowledge that this is a fact, and dare not boast that you have the enemy under your heel.

Jacobi's epigrammatic remark, that it takes brains to treat pneumonia, and Lee's statement, "Let it be remembered that every case of pneumonia is a fight for life," are words that should flash through your mind the instant you suspect pneumonia. "The treatment of all pneumonics must be individualized." It is but a step in logic to follow this up with the assertion that all diseases must be treated individually. It is easy for us as homœopaths to grasp this truth. Elsner, in quoting it, offers it as a revelation but does not mention the author.

Pneumococci, isolated from pneumonics, are divisible into three groups. This fact may prove important in the development of specific therapy, as powerful antisera have been produced against two of the groups.

Division of the cases for therapeutic purposes:

I.—Cases which, if cautiously piloted with reasonable care, will recover.

II.—Cases which are seemingly fatal from the very beginning, overwhelmed with toxemia.

III.—Cases which for a time hover between life and death, in which therapy accomplishes much.

The cases under Class I, the pathologists tell us are due to one of the above-mentioned groups, and may be likened to raw recruits in warfare, easily routed. The cases under Classes II and III are due to other recognized groups and may be likened to seasoned and shock troops, who neither give nor take quarter. Now we are ready for the assault.

Whom does the enemy choose for the battlefield? Name the next of your patients to be the victim. Are any barred because of age, sex, race, occupation, or mode of living? I will choose such a one for my theme tonight, familiar to you all. A young person in the thirties who, with no organic disease,

strong, vigorous, active, robust, immune to many other diseases because of these facts, is infected and suddenly and rapidly develops the symptoms of this disease as you have heard them described to you.

I believe the time for greatest care of a pneumonic is in the beginning of the disease. In bed at once with a suitable well-trained nurse, capable of obeying orders, as well as having a knowledge of the disease to be treated. Select a quiet, cheerful room with home surroundings; isolate the patient for two reasons—one, to protect others, but most important of all, to exclude members of the family, friends and visitors. Through this word, isolate, you can gain protection for your patient when all other arguments fail. Given seven or ten days isolation in the beginning, and you will have control or will not need the precaution.

Open-air, porch, or well-ventilated room, which? What does common sense teach you? Quality and temperature of air? By quality of air, I mean the best you can get with open windows in that particular location, and with a regular temperature of 60 to 70 degrees, day and night, whether the outside temperature be 0 or 80 degrees.

I do not believe low temperature is logically helpful. These organisms abound and flourish in the season of the year when the temperature is below 70 degrees. The breathing of air of a low temperature for refrigeration purposes is a delusion. Do you know of any one advocating zero or freezing temperature for pneumonia when it would have to be artificially produced?

Make use of the energy and sympathy that go to waste in visitors and try by well-directed efforts to have an even temperature of the sick room, day and night.

Knowing I was about to have pneumonia and having the means to command, I would remove myself from Philadelphia tonight to a warmer climate where I could have open doors and windows, sunshine, no artificial heat, and a temperature of 60 or 70 degrees, with moderate altitude. I would not go farther north seeking a low temperature.

I have observed that a man's home is a good place for him to be when sick, while for a woman the hospital is the better place. Hospitals are often noisy places and the antithesis of what I have just stated to you to be the most helpful conditions.



Having determined your patient has lobar pneumonia, why subject him daily to examinations as to the lung lesion unless some complication is suggested? For the same reason you would examine in typhoid fever for the number of ulcers in the intestines, if it were possible. You have determined it is pneumonia, then concentrate your attention on the toxemia that is present and to the one point of all: that if the toxemia is to be fatal in three to fourteen days, it will be through its deadly effect on the heart. Pneumonics are not likely to die within ten days from the pathological changes in the lungs, excepting acute edema.

The diet; liquid. Assuming your nurse to be the good sensible one known to you, that is enough to say. Otherwise explain to her that this means feeding at three hour intervals, six feedings to the twenty-four hours, omitting one feeding at night if the patient is asleep. There should be four to six ounces in a feeding. Choose broth (whether lamb, chicken or beef) consulting the patient's taste; milk, tea, coffee or cocoa. Of milk (junket), three feedings; broth, two feedings; tea, coffee or cocoa, one.

A good sensible nurse will understand that the principle is thirty-six ounces of nourishment every twenty-four hours, best suited as to time and quantity, to that particular patient, each particular day. Cold water freely, whether desired or not. Orangeade may be substituted for water. Within three or four days, the diet may be changed to a soft one, if the patient is doing well and expresses a desire for food. A sense of hunger and a desire for food, while not the only guide, is a sure sign of improvement; not that such hunger is to be gratified according to the patient's choice—the patient's desire for baked beans or ham and cabbage only leads to the addition of custard, or something as simple, to the diet.

Underfeeding is to be guarded against. To my way of thinking, food, properly digested, must be of help in maintaining strength in the muscles, and that includes the heart.

The diet of convalescence must be left for further consideration at a future time.

Bathing and external applications are matters for attention. Daily sponge bath for cleansing purposes in the forenoon in a favorable case. For a high temperature case, cold sponging of the extremities and back will lower temperature as well as cleanse, and if given at night will act as a soporific.

Guard against turning or moving such a patient, by sponging the extremities only. Local applications for pain are helpful in subduing it, and so to that degree assisting in curing the patient. I do not believe they have any material action directly upon the pathological process or upon the toxemia. Perhaps the psychical element is the chief gain.

Much of this is trite to you, and you will say, "What we want is a knock-out blow, which, when it strikes will settle the whole question." This, then is the time to introduce the subject of internal medicine.

No greater diversity of opinion exists in therapeutics than is evident in the expressed opinion of writers upon this subject. Few men have a well-defined method of treatment—using the term "well-defined" in the sense that it is a method for a series of cases. The one who comes nearest to it is Dr. Charles H. Duncan, of New York City. His system of autotherapy is simplicity itself. His article in the *Journal of the American Institute of Homoeopathy*, a year ago this month, is so optimistic that if each one of us could duplicate his results in our practice, it could be said that the problem is solved.

Dr. Clarence Bartlett, in the May number of the *HAHNEMANNIAN*, gives an item from the *Therapeutic Gazette* upon Chlorine, in which the author says he has treated 72 cases of pneumonia with but one death. The comment of Dr. Bartlett, that this almost makes us feel that the author does not know pneumonia when he sees it, or that he has been particularly fortunate in his class of cases, is what most of us believe when we read of such wonderful results. Why enumerate the various cures of the past? The scrap pile is there if you care to look it over. There is one system which has not reached the scrap pile, and that is the system that Hahnemann gave us. No matter if some men do scrap it, there are always others to fill their places and so the system goes on. It has the vitality of Truth; neglected, or forsaken, it lives on!

Let us accept this system as the living truth, and endeavor by every means in our power to search out wherein and whyfor it fails with some individuals, while with others it is successful. The article in the February number of the *A. I. H.* is worth your consideration. Dr. T. A. McCann, of Dayton, Ohio, says, "I have treated 1,000 cases of influenza and have no losses." True, we are not considering influenza, but surely

no man can have so many cases of influenza without a certain number of pneumonias among them. He further says this: "Careful attention to *detail* has given me 100 per cent. cure. Give all credit to homœopathy." Apparently we have to go far west for real enthusiasm.

In the same article, Dr. A. B. Howe, of Bridgewater, S. D., says: "I have treated 267 cases of influenza without a pneumonia or a single death." Allow me to emphasize that part of Dr. Howe's statement in which he says he did not have a case of pneumonia. It enables me to confirm my belief in the efficacy of the properly selected homœopathic remedy in the early stage of pneumonia as well as in other diseases. Its greatest efficacy is in the arresting or modifying of the disease. These remarks are but preliminary to the real battlefield.

It may be any time from the second day on, when toxemia and its consequent effect on the heart is manifested. Now is the time when brains are needed; when it is a fight for life. Granting that you have selected the homœopathic remedy, *the only one*, yet it is still self-evident that the heart is failing, what are you to do to keep the heart going?

This is the time when a thorough knowledge of the heart by all the known physical signs is of the greatest importance. Who is so able to appreciate the impending danger as the clinician who has most carefully studied the heart in health and disease? Whose ear can detect the failing first sound at the apex; the increasing feebleness of the second sound at the second right intercostal cartilage, and who then can so wisely estimate the ability of this wonderful motor to carry its load with or without the aid of a drug?

The one drug is yet to be discovered that will overcome this dangerous condition. Few there be who have not tried to do it with digitalis. Some who have failed have been accused of timidity in not giving enough: others who have failed, of giving too much.

Truly the use of this drug is well summed up in Dr. Williams' paper on the use of digitalis, in two words, using the vernacular, the "Know How." Billing's Forcheimer's (translation) Therapeutics says digitalis should be given (a) from the beginning in every pneumonia where the heart muscle cannot be trusted; (b) at any time in the course of this disease when any symptoms of cardiac weakness are noted. Hare



"believes that the cases of pneumonia which are most benefited by its use are those in which the circulatory failure is due to cardiac fatigue and the heart is less poisoned by the infection." Such quotations as these may be added to from many eminent authorities. If you care to search them out and ponder over them, I believe you will come to this conclusion, that you will have to study the heart most thoroughly to use digitalis successfully in pneumonia.

To those of you who want to know how to appreciate the heart in pneumonia, take note of this quotation from Forcheimer who says the treatment of the cardiac toxemia of pneumonia must include blood-pressure study, which gives an *unerring* index to the treatment which should be carried out in the majority of cases. If you want this matter of blood-pressure in a predigested form, take the article by G. Morris Golden in the HAHNEMANNIAN MONTHLY for May, 1919, on some factors in blood-pressure useful to the general practitioner.

At this point, permit me to call your attention to the mortality rate in this disease. To be brief and to illustrate my point, I will ask you to accept these figures from Osler: "The mortality progressively increases from the twentieth year, rising from 3.7 under that age to 22 per cent. in the third decade, 30.8 in the fourth decade, 47 per cent. in the fifth decade, 51 per cent. in the sixth, 65 per cent. in the seventh.

"Analyzing a series of fatal cases you will be much impressed by the number of cases in which the organs show signs of the degeneration that must have preceded this disease." Accepting these mortality figures as true, is it not plain to us that age and degenerative change are important factors in this matter of heart stimulation?

Will digitalis avail us in that class of 3.7 mortality as it will in the 51 per cent. class? No. Will digitalis be of the same value in an alcoholic or one who has had a previous degenerative change in the kidneys? No. Will it not be of particular value in the individual who has had a known disease of the heart previous to the onset of the pneumonia? *Yes.*

To lessen the mortality rates according to these classes it will require the most careful consideration and knowledge of your patient from the onset of the disease; or better still, I would suggest that you have a well defined plan of treatment in advance, for each of your possible pneumonia patients.

Gentlemen, there are other drugs to be used as well as digitalis and I believe that we can formulate in advance of the onset of this disease the ones that should be used in a given case as a heart stimulant. Those that should influence the mortality rate I believe are to be found according to the Hahnemannian method, as well as those used for their physiological effect.

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### POST-OPERATIVE PNEUMONIA.

BY

J. A. HOLLAND, M.D., BOSTON, MASS.

(Read before the staff of the Massachusetts Homœopathic Hospital, May, 1920.)

POST-OPERATIVE PNEUMONIA will always occur, although it is somewhat avoidable. It happens everywhere and bears no direct relationship to pneumonia epidemics. It is rather definite in its action and no place is entirely free from it.

The varieties of post-operative pneumonia are three:

1. The so-called "ether pneumonia." This is evidenced by a sudden rise of temperature and some respiratory difficulties occurring within a day or two after an anesthetic has been given.

2. Embolic, or accidental pneumonia. This variety is slower in appearance, probably not manifesting itself until one to three weeks have passed from the time of the operation. The symptoms and signs are the same as any other type of infectious pneumonia.

3. Hypostatic or terminal. Older persons are subject to this variety, although younger people are not immune. It is caused by the lack of proper circulation of blood through the lungs and is brought about by lying too long in one position and by heart failure. Patients, who have been in very poor physical condition before the surgical intervention, are predisposed to this type.

The etiology is rather definite. About 52 per cent. of cases occur between the ages of 20 and 40. The majority of the remainder occurs in patients over 40. Fatal cases are not unknown in children.

It has been determined that there are four times as many males affected as there are females. (In our own records for April and May, the males outnumbered the females seven to

three). The mortality, however, in our small number of cases, is greater in women than in men.

The time of the year apparently has nothing to do with the condition, although it is claimed that 65 per cent. of cases occur during the six winter and spring months. Careful investigation of the records shows that August has almost the same percentage as January and February, respectively.

The percentage of surgical cases which develop pneumonia varies but slightly in different parts of the country and then it is probably due to errors in diagnosis or to improper classification. (This is mentioned because hospital reports from different parts of the country show a yearly average of 1.5 per cent. to 2.2 per cent., and when one hospital announces an average of 5.6 per cent. in a series of 1,409 cases, something is wrong either with them or with all the rest).

Our own report for April and May shows an average of 2.2 per cent. in a series of 450 surgical cases studied. This is not in excess of the highest yearly average as reported by others, and, as we have had more post-operative pneumonias during April and May than in previous months, our yearly average should compare favorably with the reports of other institutions.

Most writers claim that these pneumonias are mostly of the lobar type. (Two writers claim that in thirty cases of post-operative pneumonias, twenty-eight were of the lobar type).

The part of the lungs most frequently involved is the right lower lobe. Next in order is the left lower lobe. Third is a combination of the right upper and lower lobes. Other locations and combinations of locations are not quite so numerous.

The leucocyte count averages about 15,000, although it is quite possible to have a normal count or even a leucopenia.

The urine is of little diagnostic value except that some men claim that the urine contains precipitins which act on the invading organism. It is also claimed by the same writers that the blood contains agglutinins which also act on the causative bacteria.

It has been determined that in 77 per cent. of cases, the invading organism is the type 4 pneumococcus. Other organisms are the remaining pneumococci, the streptococci and the colon bacilli. These figures are rather striking when compared with results obtained in experiments made with "common



colds." In a series of 65 of the latter condition, it was found that the causative organism was the type 4 pneumococcus in 81 per cent. of the cases, so you see that this type of bacteria is a large factor in common colds as it is in post-operative pneumonia. This brings us to the predisposing causes in which an inflammation of the upper air passages plays a large part.

Certain types of operations predispose to pneumonia. In a series of 1,423 cases operated at Camp Devens, 30 developed the disease. Seventy-five per cent. of these followed abdominal operations, most of which were herniotomies.

Preliminary medication of morphia and atropine apparently played no part in prevention as 28 out of the 30 received a hypodermic of these drugs one hour before operation. One of the remaining cases received local anesthesia and the last had no anesthetic at all.

The condition of the patient at the time of the operation is quite a large factor. Previous operation within a short space of time lowers the patient's resistance to further interference. The surgical condition itself is important in its ravages upon the vitality of the patient.

A lower opsonic index tends to increase the patient's susceptibility.

Exposure has been long recognized as a big factor in all types of pneumonia and it is of no little significance in the type under discussion.

Patients are brought to the hospital in conveyances which are not always heated or in which the patients are chilled through the medium of open windows. Then a regulation admission bath is given. Opportunities for chilling the patient, both during and after bathing are not lacking. Patients are not averse to getting out of bed and walking around between the time of the bath and of the operation. (It might be stated here that to some of the patients that are admitted to the hospital, the shock of being compelled to take a bath is in itself a sufficient cause for a long illness. One woman, admitted for medical treatment, had no bath, nor did she comb her hair, for seven months previous to admission. When an orderly asked a male patient when he last bathed, he replied, "last summer!")

When the patient is operated, it is a well known fact that the temperature of the operating room should not be less than 80 degrees F. If this is so then the recovery room should be maintained at the same temperature.

Other and more active causes are anesthesia and sepsis.

In a series of 58 cases it was found that 81 per cent. occurred after anesthesia by the nitrous-oxide—ether sequence given by the closed method and in the remaining 19 per cent. were divided equally between the nitrous-oxide—oxygen, ether procedure (open method) and the open, drop method using straight ether.

Ether increases secretion in the upper air passages but does not influence the bronchi. Prolonged anesthesia tends to increase the amount of mucus secreted. As patient is breathing rather forcibly when the oxygen supply is cut off, or diminished through mucous obstruction, there is set up a bubbling and churning in the pharynx. This unusual disturbance dislodges the bacteria from the buccal cavity and the crypts of the tonsils and thoroughly mixes them with the mucus. By this time the patient is likely to cough and follow the same with a long, sharp inspiration. There is no doubting the fact that, in this way, extremely infectious material is carried into the lungs.

When considering sepsis as a cause of post-operative pneumonia one naturally turns to a study of the lymphatics and blood vessels as a means of transporting septic material.

The lymphatics of the abdomen are parietal and visceral. The parietal lymphatics consist of a superficial and a deep set and drain the abdominal wall. Above, the umbilicus and superficial set drains toward the axillary glands and below, toward the superficial inguinal glands. These latter eventually drain into the deeper, lumbar glands.

The deep set of parietal lymphatics follow the larger blood vessels and end in the internal mammary and in the lumbar glands.

The visceral lymphatics are between the layers of the peritoneum and drain into glands along the spine.

Thus, you see, there is no direct lymphatic connection between the abdomen and the chest. The natural deduction would be that septic material passes through a large number of glands to the right lymphatic and thoracic ducts. The infectious material then enters the venous system and passes through the heart to the lungs. Here the emboli lodge and the bacteria grow. Of course, infection may occur more quickly by following the venous system directly.

Septic pneumonias have followed mastoid operations, ap-

pendectomies, cholecystestomies, puerperal infections and, in fact, any acute or chronic septicemia or pyemia.

It is also known that appendicitis may occur at the same time as pneumonia or, indeed, may follow it. Recently, there was a case in the house with lobar pneumonia. One of the surgeons was called in consultation because of abdominal pain. As you know, pneumonia of the right lower lobe refers pain to the lower right abdominal region, simulating appendicitis. This case, however, involved the upper left lobe. The surgeon entered the abdomen and removed a ruptured appendix. This, of course, brings up the question of which came first, the pneumonia or the appendicitis? Whoever can answer that question can also decide which came first, the chicken or the egg.

Rovsing, in his work on surgery, summarizes the causes as follows:

"One curious fact should long ago have aroused the surgeons' suspicions, namely, that almost every so-called ether pneumonia manifested itself after a laparotomy, while it is extremely rare to find pneumonia following operations on the extremities, the thorax or the head. In the main it is due to two circumstances:

"1. That peritoneal infection is carried to the lungs partly by way of the lymphatics and venous blood and partly by embolism.

"2. That the sore-bellied patient, after an abdominal operation, does not dare to breathe deeply for fear of causing himself pain. The results are imperfect aeration of the lungs and diminished elimination of secretions. If, therefore, the patient is already suffering from bronchitis, or if an infection sets in, the development of pneumonia is greatly favored and encouraged by the deficiency in expectoration and lung ventilation."

The best treatment is prevention. One must guard carefully against chilling the patient while on the way to the hospital, and once there, exposure must be prevented by careful protection of the patient before, during and after the operation. No matter how well a patient is covered, he is likely to throw off his blankets and expose himself. This can be prevented by fastening a cotton pneumonia jacket to the chest as the patient leaves the operating room.

Careful, daily physical examination of the chest is advisable.



The anesthetist should be competent and should observe the following rules:

1. Patients should be well prepared. No food or water should be given them by mouth for twelve hours before the operation. There should be a minimum of fecal matter in the colon.

2. A minimum amount of the anesthetic should be given. Good relaxation should be obtained with six ounces of ether by the open method, and four ounces by the closed method, per hour.

3. Give plenty of air in the mixture.

4. The anesthetic should not be prolonged more than necessary. I have known of cases where the patient was fully anesthetized for 35 minutes before the operation was begun. Then again some surgeons unnecessarily prolong the operation.

5. When the patient has reached that stage of anesthesia where the vomiting reflex begins, the anesthetic should be forced until the patient is in the third stage.

6. The pharynx should be kept dry.

Medical cases suffering from respiratory conditions should be kept separated from the surgical patients who have not developed pneumonia.

Frequent turning of the patient and early sitting up after an operation will greatly benefit the circulation in the lungs and thus tend to prevent stasis.

When considering therapeutics little need be said, as this part of the treatment is the same as any other pneumonia. I would suggest, however, that the organism be isolated as soon as possible and measures taken to counteract its effects.

Homœopathic remedies play an important part in the therapeutics. Among the mostly indicated remedies are aconite, belladonna, ferrum phos., and veratrum viride in the initial stage. Later, when consolidation has taken place, phosphorus, arsenicum iodide, iodine, hepar sulph., ipecac and antimonium tartaricum are efficient and reliable remedies.

Bryonia is to be used, of course, but it is apparently overestimated in its ability. In its pathogenesis we find that its principal effect is on the serous membranes and not so much on the mucous membranes. The ideal place to use it would be in pleuritic complication.

To summarize:

1. Post-operative pneumonia is, to some extent, avoidable.

2. The best treatment is prevention.
3. Anesthesia should not be entrusted to an incompetent person.
4. Rigid supervision of the pre-operative and post-operative treatment is advised.
5. Immediate typing of the organism and a suitable treatment instituted.
6. Carefully select your homœopathic remedy.

## BIBLIOGRAPHY

- Embolie Pneumonia following mastoid operations. (Richards) Boston M. & S. Jour. 175: 206. Aug. 10, 1916.
- Septic Pneumonia. (Litchfield) Med. Jour. of Australia. 1: 197. March 4, 1916.
- Ether Pneumonia (E. G. Darnell) American Jour. of Obstetrics. 75: 426 March, 1917.
- Post-operative Pneumonia. (S. Israel) Laryngoscope 27: 102. February, 1917.
- Septic Pneumonia. (S. Sheill) Practitioner 98: 577. June, 1917.
- Fulminating Appendicitis complicated by pneumonia. (G. S. Foster) International Clinics 2: 226. 1918.
- Common colds as a possible source for lobar pneumonia. (E. Valentine) Jour. of Experimental Medicine 27: 27. Jan., 1918.
- Post-operative Pneumonia. (E. P. Joslin & H. Gage) Med. Clinics of North America 2: 469. Sept., 1918.
- Study of Post-operative Pneumonia. (A. O. Whipple) Surg. Gyn. & Obs. 26: 29. Jan., 1918.
- Post-operative Pneumonitis, further studies in, (M. Cleveland) Surg. Gyn. & Obs. 28: 282. March, 1919.
- Recent studies in Post-operative Pneumonia. (A. O. Whipple) American Jour. of Surg. 33: 2. (Anesthesia Supplement, January, 1919.)

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THE TREATMENT OF URETHRAL CARUNCLE.—J. L. Crenshaw (*Minn. Med.*, 1920, III, 54) states that urethral caruncles almost always occur on the posterior and lateral walls. Their treatment has been unsatisfactory, and their recurrences after removal numerous. Good results, however, have been obtained by Crenshaw by means of the following operation:—The patient is placed in the lithotomy position and, after the cleansing of the parts and the application of a local anesthetic, each tag is picked up with small Graefe fixation forceps and clamped off, in the longitudinal axis of the urethra, with a special clamp. Care must be taken to include all of the caruncle, but none of the submucosal structures of the urethra. The caruncle is cut off close to the clamp, and the cut surface of the base cauterized with acid nitrate of mercury solution. The removed tags are afterwards examined microscopically. Hemorrhage does not obscure the field of operation nor occur subsequently, and the surgeon may be sure that he has removed all of the growth. Very little scar tissue results, and what does occur is in longitudinal lines, separated by healthy mucosa. Thus prolapse of the mucosa from contraction of scar tissue is avoided. The symptoms are almost immediately relieved. The author has treated 118 patients in this manner during the last four years, and knows of but four recurrences.

## EDITORIAL

### LETHARGIC ENCEPHALITIS IN CHILDREN.

SINCE the recognition of lethargic encephalitis as a clinical entity, numerous cases of this disease occurring in children have been reported. Josephine B. Neal has seen fifty-eight cases in children under fifteen years old and her report is the most valuable contribution to the study of this disease at present available. At the last meeting of the American Pediatric Society, La Fetra reported eleven cases while numerous others were referred to in the discussion. The newspapers are constantly reporting alleged cases, the diagnosis of which, however, cannot always be accepted.

There is naturally still some confusion in our conception of lethargic encephalitis and consequently the diagnosis is difficult. We are in the same position regarding encephalitis in which we were some years ago regarding poliomyelitis. Until the fact was recognized that there are several forms of poliomyelitis, namely the abortive type, the cerebral type and the fulminating type as well as the spinal, or paralytic type, many cases were overlooked and frequent mistakes in diagnosis were made.

The same may be said of encephalitis at the present time. Flexner calls attention to the fact that there are several types of encephalitis and he mentions the six groups which McNalty has described, this classification including cases with general symptoms but without localizing signs; cases with general disturbances in the function of the central nervous system associated with either third nerve or facial nerve paralysis; cases in which spinal manifestations predominate; cases with polyneuritic manifestations and the so-called "abortive cases."

The characteristic clinical picture is given by Neal as follows: A gradual onset; marked lethargy and asthenia; headache; low irregular temperature; frequent cranial nerve palsies. The course is not so prolonged in children, as a rule, as in adults, the average duration being six weeks. There are fewer paralyzes and fewer disturbances of vision.

Encephalitis must be differentiated from tuberculous meningitis, brain tumor, cerebral syphilis and the cerebral type of poliomyelitis. Differentiation from the latter, especially in certain mild cases, is impossible. Even laboratory findings do not help here.



The blood shows a slight leucocytosis. Blood cultures are sterile. The spinal fluid shows practically the same picture as in poliomyelitis. These findings may be summed up as slight increase in the amount of fluid which is clear and shows a cell-count of 100 to 200, mainly mononuclears. Albumen and globulin are increased. The sugar-reducing property is normal.

Fourteen out of Neal's series of fifty-eight cases died. Ten are reported as cured and the balance recorded as recovered. The prognosis as to life is, therefore, similar to that of poliomyelitis. Neal feels that lumbar puncture is of decided therapeutic value and should be resorted to in all cases.

C. S. R.

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#### THE RECENT STATE SOCIETY MEETING.

THE Fifty-seventh Annual Session of the Homœopathic Medical Society of Pennsylvania was held at the Penn-Harris Hotel, September 21st to 23rd, inclusive, and was, with few exceptions to be hereafter noted, a pronounced success; indeed, it may well be described as a most brilliant affair.

While detailed mention of this meeting would appear not to be of interest to many of our readers, nevertheless, by reason of the fact that our circulation is country-wide, and that Pennsylvania is our banner Society, makes it advisable, for the benefit of others, to have detailed remarks concerning what took place.

We had with us the Hon. George A. Hoverter, Mayor of Harrisburg, who made his remarks brief and to the point, omitting the usual conventional inanities to which visitors are treated and which they generally regard as an unmitigated nuisance. There was Success No. 1, and the response thereto by the President was just as sensible.

The President's address was noteworthy for its brevity and clearness of diction and good sense of which our readers will be able to judge for themselves.

Of the important committee reports that on Legislation attracted considerable attention. It has been the policy of the Pennsylvania Society for a number of years to make certain committees more or less permanent in their composition, thus insuring efficiency in the work by reason of the experience gained by years of service. Dr. E. A. Krusen has now been on

our committee for several years, and each year has proven the work of his committee to be better than the preceding.

The Membership Committee reported one hundred and seven new members. Good though this seems to be, it was disappointing, as the Committee started out to get two hundred. The method employed that brought the best results consisted in sending broadcast to members a list of the physicians in the State who were not members. This resulted in many of the men taking an active interest and on their own initiative writing to their friends in such numbers that non-members felt constrained to join if for no other reason than to lessen the labors of their postman. In fact, one member did join for that reason—at least, he said he did. Furthermore, publication of that list brought into the hands of the Committee definite information as to the ethical standing of a number of men who were out.

The list furthermore demonstrated the importance of concerted action of County, State and National organization, there appearing to be none of this spirit of getting together existing at the present time.

The Scientific Program opened with the Bureau of Sanitary Science. As usual, there were listed a number of eminent official sanitarians. These gentlemen have usually come to our meetings, feeling that it was their due or prerogative to usurp the entire session and speak for a period of time limited only by their own sweet will. Imagine, therefore, the pleasure and the surprise created by Colonel Edward Martin, M.D., Commissioner of Health of the State of Pennsylvania. He arrived with a team of two speakers. He announced that he and his colleagues would speak for fifteen minutes, all told. He made a few introductory remarks and introduced his men. Then instead of flying out, he quietly sat down and watched and listened all the time as his team spoke. Brief though the time occupied by the remarks of these men was, every minute was spent in saying something. In other words, fifteen minutes of ideas and a zero of verbosity. We understand that this program is a regular one for Colonel Martin and his assistants. They work on the principle that what cannot be said in fifteen minutes is worthless. It is to be heartily commended as an example to be followed elsewhere. If the example is taken to heart sanitarians will become as popular as speakers as they have in the past been a nuisance. The man is very exceptional

who can talk for an hour or an hour and a half and preserve the interest of his audience.

The balance of the scientific program was up to the usual standard of the Society. It was, however, open to the very serious criticism that no time was afforded for the discussion of papers, which, after all, is the portion of the Society program that gives those in attendance the greatest pleasure and from which they believe they will derive the greatest advantage.

The social aspects of the meeting, that is, the entertainment of visiting members, was under the care of the Central Pennsylvania Homœopathic Medical Society, a small organization of approximately thirty members of whom twenty were said to be active in the promotion of the details of the entertainment. No large city of the first or second class could have distinguished itself to a greater extent than did the physicians of the Central Pennsylvania. The smoker and the banquet can well be said to have exceeded many of their predecessors in the various details that go to make such successful. The numerous social affairs arranged for the ladies were likewise in the highest degree commendable. Indeed, we may refer the example set by Central Pennsylvania to the physicians of the country to show what a small body of men can do if they only have the determination to do it. They have proven conclusively that the excuse so often given by others, that there are so few of us, is absolutely absurd. It is the will to do that brings success. One man alone can do at times more than fifty individuals belonging to the hold-back class.

On Tuesday evening of the week of the session a discussion on State Health Insurance was opened by Dr. Wm. M. Hillegas, Dr. Robt. P. Piper, the President of the Society, presiding. We had with us the various members of the Compulsory Health Insurance Commission appointed by the Governor of the State, some of whom made remarks. Speaking personally and for no one else, we would say that, after listening to the remarks of the Chairman of the Commission, we feel that if his influence should be wide-spread, the danger of the passage of a Compulsory Health Insurance law in Pennsylvania is very great indeed, especially so as he occupies high office in an industrial community. Apparently his statement of the situation seemed to be fair. The impression, however, that he created with us was that, down within the depths, he is preju-



diced heartily in favor of such a law. He is a layman and as such appeared to be swayed by a lack of knowledge of what constitutes a real medical examination and a real prescription. As his remarks as well as those of the other speakers, will shortly be published in the *HAHNEMANNIAN*, we leave our readers to judge for themselves.

To us the attendance at the meeting was disappointing, a trifle over two hundred members being present at the different sessions of the Society. This was just about equal to the previous Harrisburg meeting in 1908. This was offset in a measure by the interest taken in the sessions. We must confess that we have never attended a meeting where members were so faithful in their presence at the meetings as they were on this occasion.

The exhibitors were most favorably placed. It was necessary to pass the entire length of the corridor in which they had their displays in order to reach the meeting room. While members interviewed the exhibitors, they never were observed there while the active program was in progress. The exhibitors themselves appeared to have been carefully selected, as the articles advertised were strictly of an ethical character.

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#### NATIONAL HOMŒOPATHIC CLINIC DAY—LAST CALL.

THE many committees in charge of what we hope will be an annual function in our hospitals, have completed their arrangements. Nothing now remains excepting the perfecting of final details in our many institutions. The principal point of interest at the present time involves the awakening of general interest to secure good attendance. This may not come the first year, for physicians do not care to leave home and practice even for a day unless some advantage is derived from the trip. The initial responsibility, therefore, rests upon those in charge of the clinics, and they must exert their best efforts to make each and every clinic worth while. The smaller institutions, probably for the first time in their history, have an opportunity for coming into prominence, and showing the communities in which they operate, the ability that resides within them. Large hospitals with a reputation must maintain the same, and seize the opportunity to become still greater.

NEVER HAS THERE BEEN AN ENTERPRISE SO PROMISING FOR GOOD AS THE NATIONAL HOM-

CEOPATHIC CLINIC DAY. LET NO ONE FALL DOWN IN HIS WORK.

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**NATIONAL CLINIC DAY IN PENNSYLVANIA.**

It is unfortunate that we cannot give full particulars concerning the observance of this day in all the Pennsylvania Homœopathic Hospitals. We know that in Pittsburgh, the enthusiasm over the occasion is all that can be desired, and that not only will Drs. Moreland and Calhoun, who are in charge of the movement in that city, see to it that clinics of unusual merit will be presented, but the evening address and collation will afford a fitting termination to the day. In the hospitals throughout the State, at Scranton, Wilkes-Barre, Reading, Harrisburg, Chester, West Chester, Norristown, and elsewhere, the arrangements are being perfected.

In Philadelphia, clinics will be held in the Women's Homœopathic Hospital, the Children's Homœopathic, the West Philadelphia Homœopathic, the Women's Southern Homœopathic and Hahnemann Hospitals. The programme of the latter is now at hand, and includes the following: Two sets of clinics will be run simultaneously from 9 A. M. to 5 P. M., as follows:

**MEDICAL.**—9 A. M., G. Harlan Wells; 10 A. M., C. S. Raue; 11 A. M., G. Morris Golden; 1 P. M., Clarence Bartlett; 2 P. M., W. R. Williams; 3 P. M., O. H. Paxson; 4 P. M., Ralph Bernstein.

**SURGERY.**—9 A. M., Ear Clinic, G. J. Palen; 10 A. M. to 12 M., Gynecology, D. Bushrod James; 1 P. M., Cataract Extractions, Wm. M. Speakman; 2 P. M., Genito-urinary Surgery, Leon T. Ashcraft; 3 P. M. to 5 P. M., General Surgery, H. L. Northrop.

If the attendance is too large for the accommodation of visitors, the various laboratories of Hahnemann College will be opened for demonstrations.

In the evening a public address by an eminent visitor is being arranged.

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**A SIGN OF BETTER THINGS.**

OUIJA boards are now advertised by department stores at 40 per cent. discount from prices quoted last spring. Why complain of the high cost of living? Perhaps the public is regaining its sanity!

## GLEANINGS

### MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

THE CONCENTRATION TEST FOR RENAL FUNCTION.—Mosenthal calls attention to the value of this test which he assures the readers is of easy application in ordinary practice and possesses distinct value as a prognostic point. The principle of the test is that any kidney that is capable of excreting a urine of normal or above normal specific gravity at some time in the course of the twenty-four hours cannot be a very bad kidney, and, therefore, the prognosis is relatively good. No preliminary test diet is necessary, the patient simply follows his ordinary routine of life with the exception that he is instructed to urinate every two hours and preserve the entire specimens in separate bottles properly labeled. The physician in charge of the case can then determine the concentration power of the kidneys by noting the specific gravity of each specimen.—*The Medical Clinics of North America*, Vol. IV, No. 1.

THE FATE OF THE FRIEDLANDER BACILLI INTRODUCED INTO THE UPPER AIR PASSAGES.—Bloomfield continues his experiments with the various micro-organisms and their effects upon the normal mucous membranes. This time he deals with the Friedländer bacilli and presents the following conclusions:

1. Friedländer bacilli freshly isolated from various sources were introduced into the normal upper air passages without producing local or general disease.
2. The organisms disappeared rapidly—usually within twenty-four hours.
3. It was not possible artificially to produce a carrier state.
4. The bacteria are removed by mechanical means.
5. This group of organisms when associated with disease usually act as secondary invaders.—*Johns Hopkins Hospital Bulletin*, June, 1920.

RENAL CALCULUS WITH NEGATIVE X-RAY FINDINGS.—Hyman reports four cases which serve to illustrate the following interesting facts: 1. Negative radiographic findings in renal lithiasis are not infrequent, four such cases being observed within the period of a few months. 2. Latent kidney stones are also not uncommon; in two cases there were no symptoms referable to the side on which calculi were found. 3. The chemical analysis showed urates to be the predominating constituent in all four cases. 4. The passage of a ureteral catheter unobstructed into the pelvis of the kidney does not prove the absence of a ureteral calculus. 5. The wax-tipped bougie is of value; it will every now and then demonstrate the presence of a stone when other means fail. 6. Conservatism should be the watchword in all operations upon the kidney. Nephrectomy should be practised as a last resort, for



despite negative radiograms, and absence of symptoms, the opposite kidney may be the seat of calcareous disease.—*Boston Medical Journal*, July 15, 1920.

**ACTION OF UREA IN REMOVING DROPSY IN PARENCHYMATOUS NEPHRITIS.**

—The fact that increased concentration of urea in the blood accompanies the clearing up of the oedema suggested that possibly urea itself might act in the same way. To test this we have given large doses of urea to several patients with marked ascities and oedema, with the result that in each case the dropsy gradually disappeared. The treatment, to be successful, must be persevered with for several weeks or even longer if necessary. Thirty grammes or more of urea may be given per day. We generally give two doses of 15g. dissolved in a little water every 24 hours. Soon the amount of urine passed increases greatly and may be double or treble the ordinary amount.

In one case in which this treatment was tried the patient (a female) was absolutely water-logged, and it would be difficult to imagine a more intense oedema and ascites than she exhibited. After a month of urea treatment she began to improve and in three months was quite free from dropsy. She left the hospital and stopped taking urea. In about a month she returned suffering from both oedema and ascites, which were almost as marked as at the beginning. After a fortnight on urea this cleared up entirely. She was watched for some time and the urea gradually cut off. She is now quite free from oedema and ascites, although she has had no urea for several months.—*The Lancet*, June 19, 1920.

**AFTER HISTORY OF PARENCHYMATOUS NEPHRITIS CURED OF DROPSY.**

Probably the most dangerous variety of chronic kidney disease is that of parenchymatous nephritis accompanied by well-marked oedema and ascites. The tissues become water-logged, and unless relief is obtained the heart and lungs become embarrassed, and the patient dies, we might almost say, from drowning. Although the treatment mentioned above may often succeed in removing the dropsy the renal condition is not influenced, and the proteinuria remains as marked as ever. Though the patient is not cured it is most important to relieve the dangerous dropsical condition for in the rare cases that survive there seems to be a tendency to pass from the stage in which oedema is one of the most distressing symptoms to one in which the symptoms represent those of chronic interstitial nephritis. When this stage is reached the immediate danger to life is much less and the patient may live in comparative comfort for many years. It is thus most important to prevent the ill-effects of excessive water-logging of the tissues by all means in our power, for if we succeed in keeping the patient alive for some time and get rid of the oedema by appropriate treatment it is reasonable to expect that the condition will change, and the tendency to oedema with its immediate danger to life will be in many cases gradually passed over.—*The Lancet*, June 19, 1920.

**THE QUESTION OF PROTEIN DIET IN INTERSTITIAL NEPHRITIS.**—There does not seem to be any theoretical objection to giving protein or urea in large amounts to parenchymatous cases in which there is no retention of nitrogenous products in the blood. In interstitial cases where such retention tends to be more or less well marked, it is generally considered that protein, especially in the form of meat, is, on the whole, contra-indicated. There is, however, no proof whatever that protein acts detrimentally even in advanced interstitial nephritis, but, on general principles, it is probably best in the

present state of our knowledge to limit the intake of protein in patients showing marked retention of nitrogenous products in the blood. This appears to be the general practice, and it is no doubt a good one. On the other hand, it seems quite certain that milder cases of interstitial nephritis are not benefited by very strict dietetic limitations. It is customary for many medical men to order a very strict regime very low in protein content in many cases in which the renal condition is by no means bad. At present many hundreds of men who contracted nephritis on military service, and who will still show some albuminuria, are really suffering far more from the effect of low diet than from their renal disease. In the course of the last few months we have seen a large number of such cases in connection with nephritis work being carried out for the Ministry of Pensions. As the result of very many observations we are convinced that, in general, patients suffering from interstitial nephritis of moderate severity should be allowed a fairly liberal diet in which protein need not necessarily be cut down to any great extent. In very severe cases it is probably best to depend chiefly on carbohydrate food. The whole question of the effect of protein diet in kidney disease still requires much investigation, but it is certain that the custom of feeding patients practically on slops for long periods does more harm than good.—*The Lancet*, June 19, 1920.

THE "DORSAL POINT" IN HEPATIC COLIC.—In *Lyon Medical* Dr. Raymond Pauly has described a sign which appears to be of considerable value in the diagnosis of hepatic colic. The so-called subjective pain point which doctors have placed considerable confidence on, he properly regards as altogether too vague. He places more reliance upon objective pains, i. e., those which are excited by pressure upon this or that particular point. Pauly now calls attention to one of these points situated between the spinous processes of the vertebrae and the border of the right scapula at the level of the fourth or fifth intercostal space at a distance of 2 or 3 cm. from the middle line. This observation is entirely new and distinct from the diagnostic point suggested by Chauffard and others. Pauly calls it the "dorsal point." The best means of testing for it is to seat the patient on the bed, with the arms in front to give support. The observer, standing on the right of the patient, presses with his left thumb on the different intercostal spaces between the spine and the right scapula, from above down. On arriving at the fourth or fifth space a painful grimace is provoked, and the patient often sits up brusquely, complaining of severe pain. As a means of control it is always useful to apply the test on the left side. Some patients complain also of pain on this side, but it is less severe. The intensity of the pain varies. Sometimes a cry of protest is provoked; at other times the patient simply says that a little pain has been produced. As a general rule, the intensity of the pain varies directly with that of the colic, and it gradually diminishes as the other symptoms pass off.

Pauly has now tested this point in twenty-one cases and believes it to be of great practical value. He has not found it in gastric and duodenal ulcer and acute appendicitis, all of these conditions liable to be confounded with gall bladder disease.—*The Lancet*, August 21, 1920.

## PEDIATRICS

Conducted by C. S. RAUE, M.D.

THE TREATMENT OF SYPHILIS IN INFANCY AND CHILDHOOD.—Leonard Findley first discusses the curative treatment of syphilis and he states that treatment by mercury alone should be discarded; mercury reinforced by salvarsan is the best method. In a series of cases under three months of age, and treated with mercury alone, the death rate was 71 per cent. The results obtained by the combined method have been reduced to a 26 per cent. mortality. He has found the mercurial ointment to be the most efficacious preparation to be used in inunctions. The intravenous administration of salvarsan is far superior to the other methods of giving the drug as there is no pain or other untoward symptoms. The site depends on the age of the patient. In infants under the age of 18 months the veins of the scalp are the most suitable. As the operation must be performed as quickly as possible, there is not sufficient time to inject large quantities of fluid, and in consequence concentrated solutions are employed. For adults the author dissolves 0.6 gram in 10 c. c. saline or distilled water and for children he uses a dose of 0.1 to 0.2 gram to 3 or 4 c. c. of water. A needle, size No. 1, about  $1\frac{1}{2}$  in. long, is used. In spite of all that has lately been written in advocacy of the longitudinal sinus as a convenient site for venepuncture, the author is distinctly adverse to its habitual selection. Though the sinus is larger than the scalp veins, it is not always easy to enter, and if the infant is collapsed it may be impossible to perform the operation. If, too, by any chance some of the drug escapes from the lumen of the sinus, irritation of the cerebral convolutions may result. And finally, should sepsis ensue, fatal meningitis results. In children over two years of age the external jugular vein is the most available vessel, or in the older, especially those that are spare, the veins at the bend of the elbow may be selected. As children cannot be expected to remain absolutely still during such an operation, an anaesthetic is usually required.

Dosage of the drug. Dr. Findley is in the habit of commencing in infants with 0.05 to 0.1 gram and gradually increasing, especially in the older children, to 0.2 or 0.3 gram. In infants under six months of age he rarely gives more than 0.15 gram. The injection should be repeated once or twice weekly until a definitely negative Wassermann reaction is obtained, after which it is advisable to give one or two further injections. The duration of the course of treatment rather than the total amount of the drug given seems to be the deciding factor in inducing a negative Wassermann reaction. The percentage of cases in which a negative result was obtained rose steadily with the number of injections given. Any preparation of arsenic may be used with equal efficacy.

Prophylaxis or antenatal treatment is the only rational method of treating congenital syphilis. Treatment of the pregnant mother by salvarsan, reinforced by mercury, invariably results, in the experience of the author, in her bearing healthy non-syphilitic children. The number of injections varies between four and eight and the total amount of the drug employed between 1.2 and 3.6 gram. One of the striking results of this method of treatment is that not only is the child immediately after the course healthy and non-syphilitic, but that these women continue to bear healthy and non-syphilitic children in spite of the fact that no further therapeutic measures have been adopted.

Dr. Findley believes that notification should be made of all stillbirths



and miscarriages as part of any antivenereal campaign, in order that treatment of the mother may be begun at the earliest possible moment.—*British Medical Journal*, August 7, 1920.

CHRONIC INTESTINAL INDIGESTION IN CHILDREN OVER ONE YEAR OLD. —Dr. Philip H. Sylvester considers the digestive disturbances beginning at the period of greatest dietary revolution, that is, at about one year, and in his paper he considers only those cases which do not digest the average amount of the average kind of suitably prepared foods. The study of many cases of chronic intestinal indigestion has shown that seldom is more than one component of the food primarily at fault. The author therefore takes up each component separately and speaks first of Fat Indigestion which is quite common after the first year. The child's appearance is not characteristic but the stools are and the diagnosis is made upon the persistent appearance of fat, in excess, over a long period, while the patient is on a normal or sub-normal fat intake. Primarily the condition *may* be due to a focus of infection which should be removed if found. The digestion must be treated, in any event, by the removal of the fat from the diet entirely. This gives the fat digesting mechanism a rest and removes from the intestines irritating and possibly poisonous by-products of faulty fat digestion. The fat can be replaced by an equal value of carbohydrates, as sugars and starches, for an indefinite period, the length of time and completeness of privation to be governed by the general condition, constantly keeping the fat intake so low that *less* than a normal amount appears in the stools.

The most common of chronic intestinal indigestions is that of carbohydrates which presents several phases:

1. Simple indigestion not associated with fermentation is characterized by the finding of large amounts of starch in the stools of normal children. Treatment consists of reducing the total starch intake; eliminating any particular starch not digested; making the food more digestible by fine division and thorough cooking; and by making the child *chew*. Occasionally sugars are at fault in which case the stools are acid and quite irritating. Reduction or elimination of sugar results in cessation of the symptoms.

2. Carbohydrate indigestion with fermentation is far more common and is always associated with bacterial activity. The patient is usually under weight; its color is poor; it has a "pot belly" full of gas; usually a large fatty liver; and its skin is pigmented. This pigmentation is characteristic of all cases of carbohydrate indigestion and is most evident on the sides of the neck, on the flanks and on the abdomen. The stools are large, spongy, often loose, usually acid, often foamy and usually containing much starch. Treatment should be aimed at reducing the carbohydrate intake to below normal and making the carbohydrates given as digestible as possible. White bread, plain crackers, cereal jellies, well-cooked cereals and macaroni, are best. Vegetables should be omitted altogether for weeks, and then tried cautiously. The protein intake should be increased. The lactic acid bacillus is antagonistic to the organisms found in this condition so buttermilk should always be given.

When the gas bacillus is associated the symptoms are more severe and last longer. Treatment aims at getting rid of the organism. This can be done by feeding soluble carbohydrates, a high protein diet and large amounts of fat-free lactic acid milk. Treatment should be kept up for months and *no starch whatever* given as long as the gas bacillus is present in the stools.

When the tests have been negative for a week or ten days, simple, well-cooked starches, such as cereal jellies, and plain crackers, may be given very cautiously. A mixture of various sugars should be used to supplement the total fuel value of the diet.

Other types of chronic intestinal indigestion which are rarely seen are those cases of fermentation associated with the production of butyric acid; those due to the inability to digest reasonable amounts of protein; those due to deficient digestive secretions; and those cases of chronic interstitial nephritis with infantilism.

In conclusion the author states that the active digestive substances borrowed from animals are of little avail clinically. Each case must be individualized. It is probable that all will be somewhat improved upon careful regulation of the diet, but few will really get well.—*The Boston Medical and Surgical Journal*, August 26, 1920.

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### UROLOGY

Conducted by LEON T. ASHCRAFT, M.D., F.A.C.S.

**THE RESULTS OF OPERATION FOR THE REMOVAL OF STONES FROM THE URETER.**—E. S. Judd (*Annals of Surg.*, 1920, LXXI, 128) states that if, after the diagnosis of this condition has been made, there are frequent and severe attacks of pain, treatment should be deferred for a while in the hope that the stone may pass spontaneously. Nevertheless, it should be remembered that great pressure in the ureter and kidney may cause hydronephrosis. If the stone is not seemingly giving rise to any symptoms, it should be removed unless contraindications to its removal exist. In some cases the stone may be dislodged from the ureter with a ureteral catheter or small sound, especially when the calculus is at the ureteral orifice. When pyelonephritis has resulted and there is evidence of general infection, it is best not to remove the stone, if the opposite kidney has good functional power. If the stone is in the lower third of the ureter and the kidney is greatly damaged, nephrectomy should be performed, the calculus being allowed to remain. Later, if it produces pain, it may be removed. If the obstruction is so great that the function of the kidney on that side cannot be determined, the stone alone should be removed. In cases of chronic kidney infection, conservative methods should be followed; but in acute, severe infections, radical means should be used. Nephrectomy is the operation of choice, but the kidney should be allowed to remain if not extensively involved, as its function may be recovered. In cases of bilateral stone, operation should be performed on one side at a time. The author begins with the side on which there is acute trouble, or, in case there is no difference in this respect between the two sides, on the one with the least function. Operative removal of calculi from the ureter is a major operation, but it may be performed with practically no mortality and with good results.

**FUSED KIDNEY, WITH CALCULUS IN THE PELVIS.**—A. Hyman (*Internat. Jour. of Surg.*, 1920, XXXIII, 48) reports a case of this condition in a man twenty-four years old, whose symptoms had begun two years previously. The X-ray showed what appeared to be a ureteral calculus, about the size of a cherry, in the left lumbar region, near the iliac crest. Cystoscopic examination was negative. A pyelogram did not show the renal outline, so X-ray

catheters were introduced and a roentgenogram taken. This led to the discovery that the right ureter crossed the spine and came into contact with the shadow of the supposed stone. The diagnosis of fused kidney on the left side, with a double pelvis and a calculus in the lower pelvis was then made, and this diagnosis was confirmed at operation, when the stone was removed by an anterior pyelotomy. The patient made a good recovery.

**ADENOSARCOMA OF THE KIDNEY.**—John Fraser (*Edinburgh Med. Jour.*, June, 1920) reports a series of seven cases of this condition seen during a period of two and a half years. In three, operation was contraindicated because of extension of the tumor; but in four, an abdominal nephrectomy was done. There was no postoperative mortality; but at the time of the report, only one of these four patients remained alive, the others having died from metastases. The living patient had had the operation performed two years previously. Success in treatment is dependent upon early diagnosis and early operation. Certain conditions, such as malignant disease of the retroperitoneal lymph nodes, hydronephrosis, tumor of the liver and splenic enlargement may simulate this neoplasm of the kidney but any rapidly growing tumor in the lumbar region of a child under eight years of age which is associated with emaciation and cachexia is probably a tumor of the kidney. The author mentions a number of points in the differential diagnosis. He examined all of the tumors that he removed microscopically by the block method, so as to obtain a knowledge of the distribution of the various types of tissue found in the growth, and of the changes that it had undergone. A nodular appearance of the surface of the growth he regarded as indicating that the sarcomatous change, which begins in the interior, has begun to make its way to the surface, and has perhaps already invaded surrounding structures, thus rendering the prognosis extremely grave. Fraser prefers the Trendelenburg position in operating, as he thinks that it makes the operation easier and lessens the danger of shock.

**THE SURGICAL TREATMENT OF VARICOCELE.**—O. Jacob (*Rev. de chir.*, Paris, 1919, LVII, 352) says that in order to diminish the action of the increased pressure of the blood column upon the spermatic veins in this condition, one must make a barrier to their trajectory by doing a more or less extensive resection of these veins. The funicular and deferential branches, however, should not be resected, but only the trunk veins. The author also fixes the testicular vein stump to the pillars of the external inguinal ring, in order to correct the excessive elongation of the cord, the exaggerated descent of the testicle and the distortion of the scrotum. He gives in detail the technique of the different steps in the operation, and states that during the present year he has performed it in 237 cases without any serious accident, and that testicular atrophy did not follow in any case. While in a few instances a kind of aseptic phlebitis developed in the testicular venous stump, all the patients have been cured.

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## OPHTHALMOLOGY

Conducted by W. M. HILLEGAS, M.D.

**TUBERCULAR CHOROIDITIS.**—In many cases of disseminated choroidal patches, with progressive loss of vision and pain in the eyes and head, Risley has seen the process arrested by the administration of old tuberculin. Tuber-



culosis must, therefore, be regarded as one of the more common causes of disease of the uveal tract. Although the majority of patients affected with tuberculous choroiditis are robust and apparently healthy, and although corresponding animal experiments may be negative, he admits for the attacks and aggravations of the disease the probability of spreading by metastases. Just as frequently is undoubtedly the propagation by continuity. Occasionally severe headache is observed in tuberculous choroiditis, as a slight accompanying meningitis phenomenon. If choroiditis is complicated by neuritis, this is not secondary, but due to direct metastasis in the optic nerve. Automatically we have pure primary choroiditis, in which the secondary change of the pigment epithelium and the external retinal layers often are strikingly slight, so that a primary chorioretinitis is out of the question.—*Penna. Med. Jour.* Vol. 2, pp 189-196.

**PUPIL IN HYSTERIA.**—Kempner describes pupillary disturbances in hysterical fits, reports a case and shows that it was one of hysteria and not of epilepsy, in spite of the dilatation, inequality and fixity of the pupil. The author believes that from the fixity of the pupil, the diagnosis of epilepsy can no longer be made in all cases, although it must be admitted that a fixed pupil in hysteria is a great rarity. He considers it likely that not only the inequality of the pupils, but also the dilation of the pupils, depends not alone on the irritation of the cervical sympathetic, but that in hysteria, similar to epilepsy, the cerebral cortex is in a state of irritation, which is to be considered as the cause of the mydriasis.—*Ophthalmic Literature*, June, 1920.

**NON-OPERATIVE TREATMENT OF GLAUCOMA.**—From thirty-two years' active practice of ophthalmology, Weeks gives his personal observations regarding the treatment of glaucoma. For many years he has made it a routine practice, when time and circumstances permit, to try the effect of miotics in all cases of glaucoma before advising operation. The miotics employed are pilocarpin and physostigmin salicylate, the former in 1-3 to 2 per cent.; the latter from  $\frac{1}{4}$  to 1 per cent. As adjuvants, jaborandi is used internally, opium at times, and free catharsis. The pilocarpin and eserin are usually dispensed in a 3 per cent. solution of boric acid to avoid rapid deterioration. Pilocarpin from 1-3 to 1 per cent. is prescribed as a preventative in many cases in which the tension is at or near the upper limit of normal, in which the anterior chamber is shallow and where there is even slight cupping of the whole or a portion of the disc.

A diminution in the field of vision for form or colors, with or without enlargement of the blind spot, is an urgent sign for operative interference.

In the acute cases local treatment is used; eserin salicylate, 1 per cent. every hour; if tolerated, a calomel purge; morphin hypodermically, and a light diet. If after twelve hours there is no diminution in the tension, operation is performed. If the tension is subsiding, operation is postponed until the eye has become as nearly normal as possible, when a broad iridectomy is performed.

For the subacute and simple chronic cases of glaucoma, Weeks prefers the Lagrange operation. The trephine he limits to buphthalmos cases and those cases with deep anterior chamber, and to cases of simple chronic glaucoma, mostly with relatively low hypertension. Following the Lagrange operation, massage is employed, beginning forty-eight hours after the operation.—*Ophthalmic Literature*, June, 1920.

**RHEUMATIC IRITIS.**—Folman states that rheumatic iritis has no definite clinical significance. He examined the clinical journals of the eye department of the Rudolf Virchow Hospital only for those cases of primary seroplastic iritis, in which a specific etiology, as lues, tuberculosis, chronic articular rheumatism, gout, diabetes, arteriosclerosis, acute gonorrhea and other diseases could be eliminated. In forty-four, or 47 per cent. of the remaining cases of "rheumatic iritis," the anamnesis elicited a former gonorrheic infection. In reality this percentage is probably higher because the infection is frequently denied. Every case of iritis of uncertain etiology ought to be very carefully examined for gonorrhea. The favorable results of specific treatment of gonorrhea suggest also for these cases, especially relapsing rheumatic iritis, the employment of vaccine therapy.—*Ophthalmic Literature*, June, 1920.

## DERMATOLOGY

Conducted by RALPH BERNSTEIN, M.D.

**IS PSORIASIS INCORRIGIBLE?**—According to Hammond, arsenic, iron, nux vomica, the potassium salts, vegetable tonics, mercury, iodids, suprarenal, thyroid and pituitary extracts and vaccines are of first importance among the internal medicaments. As to diet, he endeavors to balance it by increasing the amount of those foods which are the least harmful to the patient. He also favors the judicious use of the rays of the Alpine sun lamp, and further states that mild application of the roentgen ray can be used on the nonhairy surfaces. However, as a rule, he claims a mild ointment of ammoniated mercury applied to parts other than the scalp, where a resorcin lotion should be used, are all that will be required.—*Jour. Amer. Med. Association*.

**TREATMENT OF SYPHILIS.**—Trimble, after reviewing about 4,000 Wassermann tests, says it is his belief that primary syphilis is never cured. This belief is based on the observation of patients having had their infection a few years ago and having had modern intensive treatment. What may be the proper treatment for early syphilis he finds it difficult to say. He is inclined to the view that one primary fault lies in the too universal acceptance of the specificity of certain drugs. Long periods of latency may, he thinks, be rightfully attributed to an acquired immunity and not wholly to the treatment received. The most unfortunate state in which a patient can be found is where he harbors treponema and at the same time has nothing but arsphenamin or mercury to protect him. Trimble concludes his paper with the statement that syphilis cannot be cured, and that the best treatment is that which will give the patient the longest lease on life and usefulness to himself and society.—*Jour. Amer. Med. Association*.

**MULTIPLE BENIGN SARCOID.**—Stumpke, having reported his first case in 1913, because of its rarity now reports a second case. Boeck first described the condition in 1899; it belongs to the exanthematous forms of tuberculosis of the skin, and occupies a peculiar position not only on account of its clinical form, but also because the methods used to prove its tuberculous nature are so frequently unavailing. That the microscopic picture of Boeck's sarcoid is not absolutely characteristic for the affection, as was asserted by Boeck, has been shown by Lewandowski and others; similar changes occur in other tuberculids, as erythema induratum; also in lupus. The sharply circum-

scribed foci of epithelioid cells are not found exclusively in Boeck's sarcoid. As to treatment: In Stumpke's first case he had used tuberculin treatment, whereupon an exacerbation of the lung condition ensued, which resulted in the patient's death. He, therefore, advises caution in dealing with Boeck's sarcoid, as with all tuberculids. His second case is in a woman 35 years of age, who has been suffering for thirteen years from a stubborn type. The lesions are found mainly on the right and left cheek, and on the left upper arm. The lymph glands are not involved. All the therapeutic measures so far tried have proven unsuccessful.—*Jour. Amer. Med. Association.*

**ALKALI RESERVE IN PELLAGRA.**—Of the fifty-six patients tested by Sullivan and Stanton for alkali reserve by the alveolar air method and by the determination of the carbon dioxide bound by the blood plasma, none showed a marked depletion of the alkali reserve, about one-third showed a slightly subnormal level, while the greater number were within normal limits. There would seem to be little uncompensated acidosis in pellagra.—*Jour. Amer. Med. Association.*

**ACIDOSIS IN SKIN DISEASES.**—No marked or consistent change was found by Sweitzer and Michelson in the alkali reserve in psoriasis, acne vulgaris, eczema and seborrhoeic dermatitis. Therefore, they concluded that promiscuous alkali therapy is unscientific and inadvisable, and may produce a condition of alkalinosiis which may be dangerous to the patient.—*Jour. Amer. Med. Association.*

**EPITHELIOMA OF LIP IN A YOUNG BOY.**—In the case reported by Stephens, the tumor was first noticed when the patient was 12 years of age. It was removed by operation but in three months it had recurred. On admission to the hospital in the early part of 1920, the tumor involved the right upper lip, extended beyond the middle line to the left and involved also the right angle of the mouth and a part of the lower lip. On the right cheek adjacent to the principal tumor were several secondary nodules, which were raised and warty in appearance, but were not ulcerating. The submaxillary and submental glands on both sides were enlarged and hard, but were not adherent to the jaw. The microscopic diagnosis was epithelioma.—*Jour. Amer. Med. Association.*

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## SURGERY

Conducted by J. D. ELLIOTT, M.D.

**ACUTE INTESTINAL OBSTRUCTION. THE CAUSE OF THE CONTINUED HIGH MORTALITY; HOW THIS MAY BE REDUCED.**—Summers points out the excessive mortality, usually over 50 per cent., in this common lesion when operation has been delayed over 24 hours, but believes this can be reduced by at least one-half with proper treatment.

In addition to emptying the bowel through several incisions at the time of operation, he advocates the performance of a jejunostomy in all patients who have been vomiting foul, fecal-smelling fluids. This vomiting proves the intestinal current to be reversed and he believes that nature points out this way for proper drainage.

He sums up as follows: 1. Teachers of medicine and surgery should impress by personal acts the philosophy of early diagnosis and prompt surgical



treatment. 2. A safe two- or three-stage operation is preferable to any radical procedure which would add much risk as a complete operation. 3. When vomiting has reached the stage of being foul, fecal-smelling, always drain the small bowel as high up in the jejunum as it is recognizable. Nature points out this route. 4. Anesthesia should be local—plus gas-oxygen if necessary. 5. Post-operative. Opium should be administered after the Alonzo Clark formula. Large quantities of normal salt solution should be given by hypodermoclysis. Sodium bicarbonate and glucose in 5 per cent. solutions should be administered by the Murphy drip method. Under this treatment the skin will be active if kept warm, and reaction from shock and toxemia favored.—*Annals of Surgery*, August, 1920.

**SARCOMA OF THE CLAVICLE—END RESULTS FOLLOWING TOTAL EXCISION.**—Coley has now been able to collect, study and review 108 cases of sarcoma of the clavicle from the literature and his personal observations. At best the prognosis is far from favorable but he draws the following deductions from his studies: 1. Malignant tumors of the clavicle are comparatively rare, only 16 cases having occurred in upwards of 275 cases of sarcoma of the long bones personally observed. The greatest number belong to the sarcoma group, the few cases of carcinoma being metastatic developments from some recognized or unrecognized primary focus. 2. Sarcoma of the clavicle occurs more frequently in men than in women, probably due to the fact of the greater liability of the clavicle to injury in the male than in the female. 3. Sarcoma of the clavicle in the great majority of cases is associated with recent antecedent local trauma, either in the form of a direct blow or a severe muscular strain. 4. Diagnosis: A clinical history of pain and localized swelling of the clavicle usually following recent injury, with rapid increase in size, supplemented by a fairly characteristic X-ray picture, will usually make an early diagnosis comparatively easy without the necessity of an exploratory operation. 5. Treatment: Local removal of the tumor or even a limited, partial resection should be avoided. The treatment of choice, while the tumor is in an operable stage, should be: (a) Total excision of the clavicle as soon as the diagnosis is made. (b) As soon as possible after operation a course of systemic treatment with the mixed toxins of erysipelas and bacillus prodigiosus should be begun and continued for a period of at least six months. When possible this should be supplemented with local or regional treatment with radium or X-rays. 6. The mortality of total excision of the clavicle under modern technique is so small as to be practically disregarded and the functional use of the arm remains unimpaired.—*Annals of Surgery*, August, 1920.

**POSTOPERATIVE PULMONARY COMPLICATIONS.**—A very exhaustive study of this timely subject has been made by Cutler and Hunt. Beside reviewing the literature, they selected all patients, 1562 in number, who were subjected to operative procedures under any form of an anesthetic in the Peter Bent Brigham Hospital during 1919, for this purpose.

Of these, 55 (3.52 per cent.) developed a definite postoperative pulmonary complication and 11 of these died, a mortality percentage of 0.70 per cent., and a mortality percentage of the morbidity of 20.0 per cent.

Ether pneumonia is a very misleading term as a study of the various reports will convince that the anesthetic is not the chief factor. The incidence of these complications under local anesthesia is often very high. Henle,

for example, reports more complications with local than with any of the general anesthetics.

After discussing the general factors, as age, trauma, anesthesia, pre-existing pulmonary disease, sepsis, etc., the authors make the following summary: Postoperative pulmonary complications constitute a serious menace to any patient who submits to operation. Reliable statistics show that one patient from every thirty to fifty patients operated on, no matter what the anesthetic, develops a pulmonary complication, and one patient in from every 150 to 175 patients dies from some such complication. The factors responsible for this are complicated and not always preventable, but an understanding of the mechanism suggests prophylactic measures.

We believe that embolism from the operative field is the chief factor in the etiology of such complications. It is favored by 1. sepsis, 2. trauma, and 3. the mobility of the part. Other factors of varying importance are pre-existing lung disease, the irritation of the anesthetic and such general factors as old age, chilling and poor general condition. Such embolism may occur immediately during the operation or during the convalescence, and may be the cause equally of pneumonia, bronchitis, pleurisy, empyema, lung abscess or fatal pulmonary embolism. Embolism in the sense we use it includes the transfer of small particles which may or may not be sterile from the operative field to the lungs by either the lymphatics or blood channels. We do not presume to state that this is the sole cause or always the chief etiologic factor. And in accord with the previous study of one of us and the reports by Whipple, we believe that inhalation anesthesia on top of an existing lung lesion may in some cases be the dominant factor.

The following prophylactic measures are suggested: 1. A reduction in operative trauma in an effort to produce as few and small thrombi as possible; 2. Every effort in septic cases to prevent further extension of infection so that bacteria will not be present in the blood stream, nor sepsis aid in the setting free of thrombi; 3. To avoid, if possible, operating on patients with an existing lung lesion, however slight; 4. Avoidance of chilling both by cold packs in laparotomies or by widely gaping wounds and by exposure after operation; and 5. To make each case before operation as good a risk as that individual case can be made.

Undoubtedly, all surgeons try to carry out these obvious prophylactic measures. There is evidence that pulmonary complications follow even the simplest operations in the best hands, but the weight of evidence is overwhelming that serious pulmonary complications can be prevented to a large extent if such measures are appreciated and carried out in detail.—*Archives of Surgery*, July, 1920.

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## OTOLOGY, RHINOLOGY AND LARYNGOLOGY

Conducted by JOSEPH V. F. CLAY, M.D., F.A.C.S.

ACCESSORY SINUS DISEASE AND CHOKED DISC.—Cushing states that choked disc in accessory sinus disease is inconceivable in the absence of intracranial pressure. He lays strong emphasis upon the importance of expert knowledge and technique in the performance of intra-nasal operations. He says: "I am often urged to see patients in consultation who are in extremis from meningitis following what was supposed to be a trifling intra-nasal operation."—*Jour. Amer. Med. Association*, July 24th, 1920.

CLINICAL MANIFESTATIONS OF INFECTION OF THE LATERAL SINUS.—Emerson, writing upon this important subject, attempts to differentiate phlebitis, thrombosis and septicaemia and points out that the most dangerous case may not present typical clot formation. He indicates the variability of the symptomatology and comments upon the absence of the typical chill, high temperature with remissions and sweating. The operation findings may disclose a sinus wall bathed in pus and the wall will appear abnormal and yet the blood stream be free from infection. Changes in the sinus wall are only suggestive. While most cases are secondary to mastoiditis it has been observed as a result of peritonsillar abscess and labyrinthitis. Oedema and tenderness over the emissary vein is regarded as a constant symptom. Tenderness over the upper part of the jugular vein is rarely observed. In mild cases the febrile curve is not typical. Severe cases show chill, leucocytosis and high polymorphonuclear percentage.—*Jour. Amer. Med. Association*, August 7th, 1920.

WALLING OFF THE SUBARACHNOID SPACES; ITS APPLICATION TO THE TREATMENT OF CEREBELLAR AND CEREBRAL ABSCESS OF OTITIC ORIGIN AND, IN A GENERAL WAY, TO THE SURGERY OF THE BRAIN.—Lemaître says that the surgery of the brain is grave because of the existence of the subarachnoid spaces and that suppression of these renders the prognosis more favorable. His procedure is as follows: After the meninges are exposed a Pravaz needle is pushed through the meninges and into the brain at a point corresponding to the supposed collection of pus. As soon as a drop of pus drops from the needle, a grooved director replaces the needle, thus enlarging the opening. Then a filiform drain is introduced along the channel of the grooved director, being careful not to tear the opening in the meninges. The drain is left in place twenty-four to forty-eight hours. This acts as a foreign body causing irritation resulting in meningeal adhesions and the formation of a fibrous ring about the opening. This can be gradually enlarged by introducing a larger drain or by incising the fibrous ring in different directions. This procedure is repeated until the fibrous ring opening is six to seven millimeters, when the patient can be considered well on the way to cure. It is claimed that the two dangers of brain surgery are thus averted, meningitis and hernia.—Translation by A. Miller in *Annals of Otolaryngology and Rhinology*, March, 1920.

CONTRIBUTION TO THE ETIOLOGY OF PERITONSILLAR ABSCESS OF DENTAL ORIGIN.—Schoolman divides peritonsillar collections of pus into two classes, one designated as true peritonsillar abscess and having its origin in the tonsil infection. The infection is principally in the superior portion of the tonsillar fossa. True peritonsillar abscess is of wisdom tooth origin, the infection taking place in a space delimited by the insertion of the internal pterygoid and ascending ramus of the mandible. This may result from delayed eruption, impaction or caries of the third molar or at times the second or first molars. These cases of peritonsillar abscess are characterized by the collection of pus taking place in the region of the base of the anterior arch and somewhat lateral to it and also these cases present excessive trismus, the patients being quite unable to separate their teeth.—*Annals of Otolaryngology and Rhinology*, March, 1920.



# THE HAHNEMANNIAN MONTHLY.

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NOVEMBER, 1920

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## PRESIDENTIAL ADDRESS.

BY

ROBERT L. PIPER, M.D., TYRONE, PA.

(Delivered before the Homœopathic Medical Society of Pennsylvania, September 21, 1920.)

My address to you this morning will resemble Lincoln's speech at Gettysburg in just one respect: it will be short. I will not attempt to formulate, plan, or prognosticate, a line of action for our scholastic, or legislative bodies. They occupy their relative positions by reason of presumed merit and special qualifications. Their present accomplishments are satisfactory and except to the hypercritical, praiseworthy. If they become tardy or inefficient in the fulfillment of their respective duties, my successor can prescribe the indicated remedy.

The homœopathic profession in the State of Pennsylvania at the present time is, in my opinion, more consolidated, more energetic, and more enthusiastic, than ever before. There are at least three reasons for this condition; first, danger to our very existence as the most honorable profession in the State, barring none, because the condition, not only of men's bodies, but of their souls, depends upon the state of their health. Any laws which will tend in any manner whatever to lower the standard of the medical profession, to limit the right and will of the people of Pennsylvania to choose whomsoever they prefer as their medical advisers, and to exercise all the privileges given them by the Constitution of the United States, will be a blot on our civilization. Second, the homœopathic profession, not only in Pennsylvania, but throughout the United States, is more honored and respected than ever

before, because the record we have made during the epidemics of recent years, and the honorable and heroic deeds of OUR BOYS during the tragedies of the World War, have rendered us worthy of companionship with all medical fraternities. Third, but not least by any means, the untiring energy and zeal of our membership chairman, Dr. Clarence Bartlett, have not allowed you to forget that honor, patriotism, and even common self-respect make it obligatory upon you to belong to your Local, State, and National Societies.

Organization and team work have kept the homœopathic school from being blotted out; organization and team work have won rights and privileges in Pennsylvania and at Washington which have established our equality with all medical schools; and the man who shuts himself up in his little restricted community and confines himself solely to collecting the Almighty Dollar, and lets the other fellow fight his battles for him, is a very poor specimen of the genus homo. He may have some knowledge, but mighty little wisdom. For "while knowledge is proud that he has learned so much, wisdom is humble that he knows no more." But enough of this.

We have met here to hold the best meeting ever held in the "Keystone State," to get together in whatever pertains to the good of our profession, to forget our troubles and enjoy the benefits of good fellowship, and to take an active part in discussing the scientific part of our program. Please don't forget that.

Just a few words in regard to federation and active participation with our parent body, the American Institute of Homœopathy. I believe every member of the State Society should belong to the American Institute. The Journal alone is worth far more than the dues, and the good fellowship is both practical and beneficial. I trust this matter will be fully discussed by all and that our President, Dr. McCann, will be given a most cordial reception by everyone. Remember that no one is altogether independent, but we are interdependent. Just as his predecessor has done, he will work incessantly for your interests and advancement, but he must have your help and mine if the greatest results are to be accomplished. The greatest results in life, as well as the greatest pleasures, are attained only by sacrifice,—the process by which evolution of self-consciousness makes sure its advance; the "stepping stone" of dead men's selves to higher things."

As physicians, in the true sense of the word, I feel that we are many times careless and negligent toward the noblest part of our profession; that of preventing our patients from getting sick. I believe every physician should be a self-appointed assistant to his local Board of Health. The State Board of Health, through the able guidance of Dr. Dixon and his worthy successor, Dr. Martin, has accomplished wonders in the last few years. But I know it is not receiving the support and assistance it should from its brother and sister physicians. It may, from a narrow point of view look unethical to work against your "Daily Bread," but if you can save a baby's life by instructing its mother how to feed, clothe, and bathe it, if you can make the sweetest thing in God's creation healthy and strong by giving it the necessary lime salts to form good teeth and bone; if you can instruct your patients to eat and live, not as *you* generally do, but as sane, sensible, civilized human beings should do; if you can persuade your patients to come to you, at least twice a year, to have a general examination; if you can give a community talk occasionally in regard to personal hygiene and general sanitation, you will be more respected and honored—and your pocketbook won't suffer, in my estimation. Study all the cults of the day if you wish to talk intelligently about them, but go back to some of the customs of the Old Family Doctor—God bless him.

These are days of big brains, but big hearts must go with them if we wish to make our community a place where a "friend's something you can't buy," and "a stranger's something you can't overlook." There is nothing that humanity is so hungry for as true sympathy and comprehension, and there is nothing that is so rare. The successful physician, in the highest and noblest sense of the word, is one who exemplifies in his life and character, not only scientific, up-to-date methods in everything that pertains to the healing art, but, as closely as human weakness will permit, the life and character of the Great Physician who trod the earth nineteen hundred years ago.

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RIEDEL'S LOBE OF THE LIVER COMPLICATING UROLOGICAL DIAGNOSIS.—V. J. O'Connor (*Jour. Urol.*, 1920, IV, 91) reports two cases demonstrating the possibility of confusing this condition with lesions of the right kidney. In neither case was the diagnosis made before the time of operation. One was thought to be a hypernephroma of the right kidney; but both kidneys were found normal. In the other case, when the right kidney was exposed, it was found normal. The final diagnosis was bilateral pyelitis and Riedel's lobe.



**INSIDIOUS CAUSES OF DISEASE.**

BY

PAUL H. GERHARDT, M.D., O.E.T.A. CHIR., READING, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 21, 1920.)

THE word insidious may seem at first thought as rather illusive. A Standard Dictionary defines the word in this manner: Doing or planning harm without the victim's knowledge and working ill by slow and stealthy means. An insidious disease is one that advances to its worse stage without alarming symptoms, or a disease the cause of which may be subtle and treacherous.

Such causes, *just* such causes, were the thoughts that inspired this paper. And the further thought; how many of these insidious causes of disease can be eradicated, or at least mitigated by prophylaxis, preventive medicine, and education of the public along the lines of sanitary science.

Let me cite you a few cases to illustrate what I have in mind. Thirty years ago there were two families whom I knew well. One of eight children from 2 to 18 years of age, the other six children ranging in age somewhat younger. The fathers of these families, after being invalided for a number of years died of chronic fibroid phthisis. After their death the children of these families looked robust and were apparently healthy, for several years. Today one of the six is living and about to die of tuberculosis. The other children all died of tuberculosis at various intervals. Of the family of eight children two are living. The youngest child at 20 years of age still appeared a robust and healthy young woman, but at 32 apparently hopeless; a case of tuberculosis. The oldest boy of this family, only, has escaped the infection, the other six died of tuberculosis.

If these children would have been properly instructed and informed as to house infection and other insidious ways in which this disease manifests itself and urged to live an out of door life, would they not now be useful citizens of a community?

Within the last two months two men came to my office for eye treatment who have had active parenchymatous keratitis in childhood. One is 53 years of age; vision in one eye

5/200. No light perception in the other and entirely deaf. He cannot do any work now and has been greatly handicapped all his life. The other man, at age of 43 has vision of 5/200 right eye and 10/200 in left eye, which could be improved to 20/70 and 20/50, but even with this amount of vision he is hardly able to earn for himself and family a livelihood.

Parenchymatous keratitis is largely caused by inherited syphilis. Cases of interstitial keratitis, like other forms of inherited syphilis, or those acquired in childhood, are not uncommon, too often the patient is without a true knowledge of the nature of his or her disease and does not seek medical aid until irreparable damage has been done. It may be said the parents are responsible. Not alone; the physician has a responsibility, one of education and warning so that the living as well as the unborn child may not be handicapped through life or become a burden to society. Perhaps we must still continue to pity and have compassion for such unfortunates of our present generation, but for future generations it seems like a crime. We know the cause of this disease, we know of its manifestations and we know the remedy.

CARRIERS OF DISEASE.—Often the cause of large and costly epidemics; spread disease in a very subtle and insidious manner. Human beings, animals, rodents and insects, may be carriers. Infected and putrid food and milk are likewise factors in the spread of disease.

Some of the largest epidemics in the cantonments of the recent war were caused by carriers. Meningitis carriers all have nasal deformities, such as enlarged turbinated bones, septum deviations and sinusitis.

Nasal surgery and treatment clears up these cases. Animals, rodents and insects can and should be exterminated.

Unwholesome food is a factor in the cause of disease, often hard to detect before it is eaten. Milk containing bacteria or its toxins and filthy is the cause of many diseases of the alimentary tract, especially in children. In Reading we have been trying to put into effect a safe and sane milk ordinance, one that will work no hardship to the dealer or producer, and yet the members of council have been flooded with objections of the most absurd kinds and from apparently intelligent people.

It simply shows that the public is not yet sufficiently educated along such lines to appreciate *clean milk*, and what it will

do for them. With the help of the medical societies and other public spirited organizations the ordinance finally passed through council and now they speak of a milk referendum.

True ptomaine poisoning is rare; it is an end process of food decomposition developing only in the putrid stage; and can be easily detected if not concealed by the use of benzoate of soda, formaldehyde or otherwise camouflaged.

Botulism poison, more treacherous and apparently more common than ptomaine poison, is more likely to develop in uncooked foods, fresh vegetables, ripe olives and home canned foods—such as are made by the cold pack methods. Closer inspection of canning factories and a little common sense talk to the housewife will do away entirely with botulism. Ordinary cooking process destroys the toxin; it is unlikely to form in highly acid, salty, dehydrated foods or those preserved in syrups of ordinary strength.

Outbreaks of typhoid and para-typhoid epidemics have been traced to carriers, such as kitchen help, chefs, butchers and bakers. This group of bacteria is very resistant to heat; it requires a very high degree of heat to kill the spores and toxin.

I believe we have a State law in Pennsylvania that requires inspection and physical examination of persons who work in places where food is prepared for public use. We were rather strict about this law when first passed. We do not hear much about it now.

We have at times been negligent in giving proper and intelligent instruction to our patients in regards to their health and their future state of health. Such work should not be left altogether to public health physicians and their assistants; some of them may have the same failing we have.

The field of preventive medicine seems to hold out to the young medical student of today a larger and better future than ever before. Is he able to grasp it? Should every first-class medical college have a chair of preventive medicine? Should it be a major? Shall the field of preventive medicine predominate over the field of curative medicine? These are questions for us to answer sooner or later.



**THE PHYSICIAN AND THE VENEREAL PROBLEM.**

BY

EDWARD K. GOLDING, M.D., READING, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 21, 1920.)

PROBABLY no branch of medicine has been so meanly treated as that of venereal disease. Aside from its prostitution by the advertising specialist, most of the legitimate practitioners have treated it with contempt. Some have boasted that they did not treat such cases while others have maintained a discreet silence whenever the subject of venereal disease arose. Ignorance of its character and transmission has done irreparable damage to the human race. In one instance in particular, a physician cautioned a tertiary syphilitic not to take hold of the knobs of his office door, because, the physician explained, he might infect some innocent person.

As the great majority of acute venereal infections are first treated by the general practitioner, he is the one who needs to know just what he is doing and how to do it. At present, of those who do finally find their way to the legitimate specialist, how weird are some of the methods of diagnosis and treatment.

It is only since the Great War has revealed the large percentage of venereal disease present that the world has come to view its eradication as a real problem and an attempt has been made to standardize the methods of diagnosis and treatment because, in the last analysis, it is the medical profession that has the largest task to accomplish. The profession at large, therefore, must be taught modern methods.

At first sight, this looks like rather a large order, but if the right forces are put to work, it is probable that much good may be accomplished.

The State Board of Health seems to be the proper agency to cope with the situation. Their dispensaries, spread broadcast throughout the land, could easily be made accessible to the inquiring physician who wishes to do venereal work and a clinical as well as a technical training could thus be had. The dispensary staff could act as a teaching staff and those physicians under training could work under instruction.

Correct history taking should be taught as the treatment of many cases depends on the patient's past history.

Diagnosis, the basis upon which all anti-venereal therapy is begun, must receive the student's full attention. It depends, for most part, upon the proper collection of clinical materials such as smears from the cervical, vaginal and urethral secretions; serum from suspected venereal ulcerations; discharges from the prostate and seminal vesicles; blood and spinal fluid, etc. How often mistakes are made if these materials are not properly collected.

Microscopy should receive most thorough drilling into these physicians. A great many of them have been out of college for years and have forgotten how to use this valuable ally. No single instrument, in the armamentarium of the physician who does venereal work, is quite so useful as the microscope. In the differentiation of the various secretions of the female from gonorrhoea how often a woman can be saved an unsexing operation if the disease be recognized in its early stages and the correct treatment prescribed.

The differentiation of the syphilitic chancre from the chancroid will result in the early and proper treatment for either disease. Here a fine point in differential diagnosis will prove to the physician that no matter how good a clinician he may be, it is not always necessary to have a true Hunterian chancre present in order to diagnose syphilis. A chancre may be hidden in a group of chancroids and only by the aid of a dark-field apparatus can this lurking disease be brought to light. How different, then, will be the subsequent treatment! The prevailing habit of dusting every venereal ulceration with calomel powder before the question of syphilis has been thoroughly settled will give way to the rational treatment.

By the thorough examination of the patient, the probable source of that persistent gonorrheal discharge can be located, and, instead of upsetting the patient's digestive organs by the ineffectual use of copaiva or santal oil, the lesion itself can be treated with the proper remedies and the doctor will have a grateful patient.

When the physician has learned to correctly diagnose venereal disease the question of the proper treatment arises. Here he can be taught what is proper and how to administer it.

This is the rock upon which many a case of venereal disease is stranded. Many illustrations of the improper use of the proper remedies could be quoted. I am going to enumerate three which came to my attention lately: A young man with

gonorrhoea was given a bottle of argyrol and a medicine dropper with which to apply the remedy to his urethral canal; another gave a case of secondary syphilis two doses of salvarsan and then told the case that she was cured; a third treated a case of syphilis with mercury by mouth, and as a result the patient had a mouthful of loose teeth and numerous mucous patches. I am satisfied that these mistakes would not have happened if the physicians had known how to administer the proper remedies and had given sufficient instructions to their cases.

It is proper treatment, after all, that is going to accomplish the desired results, and for every physician who attempts to do venereal work, to do good work is going to make us all better doctors, and, therefore, better citizens.

CONCLUSIONS.—That the medical profession has the largest task to accomplish in the anti-venereal disease campaign.

That the profession at large must be taught modern methods if they are to do this work in a creditable manner.

That the State Board of Health is best equipped to teach those members of the profession who wish to treat venereal disease.

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## HYGIENE FOR SCHOOL CHILDREN.

BY

WILLIAM M. HILLEGAS, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 21, 1920.)

AMONGST the many things that the late German War demonstrated were the inefficient preparation of medical men in sanitation, and the poor physical condition of a large percentage of the young men in this country.

Medical men on entering the army found themselves poorly equipped to handle the problems of hygiene and sanitation in fixed camps or in mobile units, and found that they actually knew but little more or even less than line officers about these things. The experience they gained in military sanitation will be of great practical value to them now in public health work. The trouble here lay in the teaching in medical colleges throughout the country; the course in hygiene, sanitation, and preventive medicine being all too



short and woefully lacking, and but little importance laid on their value, indeed slurred over in many instances.

From 25 per cent. to 33 per cent. (in Pennsylvania it was even higher than that), of the six million young men called in the draft were rejected for physical defects; this is not merely deplorable, it is disgraceful. Many of the defects found should never have developed; indeed, would never have done so had these young men been trained and educated in health hygiene from early life. Thorough fundamental education in hygiene would also have instilled into the young medical student a proper respect for the course in hygiene and sanitation in college and created a demand for a more satisfactory course.

So much for the argument; now for the remedy and its practical application. The training of our boys and girls in health is one of the prime factors and great assets in life, and it is a reflection upon our entire school system if we neglect it. Health education must begin in the schools, aided, of course, by parents at home, and it cannot begin too early, and it should be an obligation of the State.

In Pennsylvania, the school code of 1893 requires that before appropriations are paid, certification be made by every school, through its local board, that all the branches included in the curriculum have been taught. These certifications are being constantly made with full knowledge that this has not been done, and hygiene is one of the branches frequently omitted. However, there is now in preparation by Colonel Edward Martin, the Commissioner of Health, a syllabus for the teaching of hygiene in the public schools of this State, which Dr. Thomas Finegan, the Superintendent of Public Instruction, assures me will be enforced, and this is being arranged so that such teaching will begin in the elementary grades. And the instruction will not be the kind that you and I had in school, either.

To a certain degree hygiene has been neglected in schools from a lack of knowledge of the subject on the part of teachers, and perhaps also because scholars have been regarding such teachers as health cranks. There are already some courses preparing teachers for hygiene, an excellent course at the University of Pennsylvania, and these courses will be added to in all our Normal Schools.

All efforts to improve the welfare of children yield far

greater return than efforts directed toward improving the welfare of adults. Hygiene for future generations is surely preventive medicine. The keynote of all health work should be prevention, and to apply this properly we must have thorough education, and we must look to our present scholars for future good health conditions for our State.

Preventive pediatrics should include the establishment of correct habits in children, which will go far toward a future healthy adult life. This training can best be done in groups in school, by the proper teaching of hygiene in the early grades. Impressions made early in life are most valuable. Begin health instruction with the kindergarten child, and emphasize it as the child passes into the higher grades. Try to establish health habits, appeal along the line of the child's pride in its personal appearance. There is nothing mysterious whatsoever in the subject of personal hygiene, nor is it by any means a fad although so regarded by many scholars; it actually is the personification of common sense.

Stripped of all unessential matters, hygiene can surely be effectively taught in the lower grades of our public schools with great value, immediate value to the child, later value in health as the child grows up, and still later to the State in adult life. However, the support of intelligent public opinion will be a great aid toward the success of efforts along this line; an educated community is an important factor in any reform. Take these thoughts home with you, and give child hygiene your support in your local schools.

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## DIET: ITS IMPORTANCE TO THE GENERAL PRACTITIONER AND SURGEON.

BY

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Clinical Professor Gastro-Enterology Hahnemann Medical College and Hospital.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 21, 1920.)

EVERY general practitioner meets in his daily work, many cases with gastro-intestinal symptoms. Often the cause of these symptoms is of very short duration and requires little, if any, treatment.

Many times, however, cases such as chronic gastritis,

chronic colitis and functional disorders demand his attention for long periods. If the physician is in command of modern diagnostic and therapeutic methods, invariably all goes well. If not, the patient soon finds himself in the so-called class of chronic dyspeptics.

My records show that the general practitioner is keen to appreciate the value of X-ray studies; that he seeks the aid of a consultant and laboratory expert, and usually makes a thorough physical examination. In short, he does all that is possible to make a definite diagnosis.

From a therapeutic standpoint, he appreciates the value of exercise, fresh air, hydrotherapy and change of environment. Yet, in the treatment of gastro-intestinal complaints, he invariably neglects the most important essential, viz., DIET.

Every internist appreciates the fact that in diabetes mellitus, nothing can be accomplished without diet. That in diseases of the kidneys, diet is a most important factor. Why, then, in gastro-intestinal disorders, the question of food is so often ignored, or improper instructions given for its use—it is hard to understand.

In my office, I have heard time and again the statement that patients were told to eat what, in their judgment, seemed to agree. One can readily understand what results can be expected from such instructions.

It has been my experience that by far the greater number of disorders of digestion are amenable to treatment and that little, if anything, can be accomplished without the aid of diet.

Here, let me emphasize a very important point which applies to the surgeon as well as to the general practitioner. A case after exhaustive study, proves to be chronic appendicitis. Both the surgeon and attending physician assure the patient that an operation will most likely relieve all of the subjective symptoms, such as pain, belching of gas, acid risings, gastric and intestinal distress. At operation the expected pathological appendix is found and removed. After the glamour of the operation is over, and the patient is again at home, he finds that many of the symptoms experienced before operation have returned. It is needless to say that such post-operative reports are extremely embarrassing.

Let us inquire into a few of the causes for such results. We know that pylorospasm is a frequent accompaniment of



chronic appendicitis; that with persistent or frequent pylorospasm, the dynamic power of the stomach is weakened. In consequence, gastric atony or chronic dilatation develops. Removing the appendix does not eliminate the sequels of pylorospasm. Therefore, after the removal of a chronically inflamed appendix, which was the cause of many gastric symptoms, the surgeon or internist should not discharge the patient until all subjective symptoms have disappeared. It is extremely important to qualify your prognosis by a statement, saying the case may require some medical and dietetic treatment after the operation.

To help you to better understand some of the symptoms in gastro-intestinal diseases, it would be worth your time to read carefully the observations of Alvarez. Substantially, he suggests that the alimentary canal is a tube, that descends from regions of high tone, high irritability and high rhythmicity, to regions of low tone, low irritability and low rhythmicity.

In other words, that from the stomach downward, the dynamic power and irritability become less and less. At the pylorus, the contractions are powerful, and grow relatively less as the rectum is reached.

From a practical standpoint these findings show: That lesions along the alimentary canal such as ulcer, kinks, adhesions, acute and chronic appendicitis increase the gradient at the site of lesion, with a reversal of the peristaltic waves.

He cites instances where the normal gut was pinched, experimentally with an instrument, and the peristaltic waves afterward studied; that the waves were seen to approach the injured area and then suddenly become reversed.

Let us assume, for example, that the gradient at the injured region was normally 40, that the injury increased it to 70—the relative increase in resistance, therefore, had its effect on the wave. It was noted that even for a long time after the injury the waves were reversed. Symptoms such as nausea, vomiting, acid risings, belching of gas, etc., have been traced to this reversal of peristalsis. Therefore, if an acute or chronically inflamed appendix has raised the gradient, reasoning from the studies of Alvarez, the reversed waves were not completely corrected by appendectomy. It can, therefore, readily be seen how a lesion and its complications can easily derange metabolism. Diet here will improve the tone of the

neuromusculature, reduce hypersecretion, hyperacidity and hyperesthesia.

Splanchnoptosis, whether congenital or acquired, is another condition wherein diet is valuable. This applies, even if the case is treated medically or surgically. With splanchnoptosis, we invariably find intestinal stasis, and deranged intestinal bacteriology, often expressed as putrefaction or fermentation. From a medical or surgical standpoint, the condition is not permanently corrected unless excessive putrefaction and fermentation are eliminated. Therefore, every effort must be made to overcome these decompositions as speedily as possible.

Such men as Bassler, Kendell, Herter, et al., have shown how the bacteriology of the intestine is influenced by diet. Feeding patients, with marked putrefaction, a diet rich in carbohydrates, changes the type of bacteria and encourages the growth of bacteria that induce fermentation. The reverse applies in changing fermentative organisms to a flora which produce putrefaction.

Since the general practitioner often treats splanchnoptosis alone or in conjunction with either the gastro-enterologist or surgeon, it is necessary that he keep this in mind. You might say that such therapy would involve too much laboratory equipment or time. Let me say that usually the equipment and time are negligible.

Of the utmost importance is a diet representing protein, carbohydrate and fat. One like the following, which is a modification of the Schmidt and Strasberger Test Diet, is valuable and simple:

MORNING.—Two thin slices of well-baked bread, with a supply of butter liberally applied. One pint of oatmeal gruel, made of 1 1/3 ounces of oatmeal, 1/3 ounce of butter, 6 2/3 ounces of milk and 10 ounces of water. (All strained.) One egg in any form.

11 A. M.—A pint of milk.

NOON.—A good sized piece of steak, or roast beef, chopped or cut in small pieces and served on a piece of toast. A bowl, or about 8 ounces of mashed potato with 2/3 ounces of butter.

4 P. M.—One pint of milk.

NIGHT.—Same as noon.

Water, ad lib.

The test diet is taken for three days consecutively, and

a specimen saved for examination on the third day. A Bauermeister fermentation apparatus is useful for the purpose of determining normal, excessive fermentation or putrefaction. It consists of three small neckless bottles, like ordinary sputum bottles. These are connected to each other with glass tubing, through perforated rubber stoppers.

Into the first bottle is placed about five grams of feces, usually softened with water. Bottle No. 2 is filled with plain water, while the third bottle remains empty. Next, incubate at 98 degrees F. for 24 hours. When no incubator is available, placing the apparatus above the kitchen range will answer.

If excessive fermentation occurs, bottle No. 1 will have changed the color of its contents to a light yellow; will be acid in reaction, and contain much gas. Bottle No. 2 will have its water displaced so that No. 3 contains part of it. When excessive putrefaction has developed, the contents of bottle No. 1 is usually brown in color, alkaline in reaction, putrefactive in odor, with little if any of the contents from No. 1 forced into bottle No. 2.

Bottle No. 3 usually remains empty.

As a means of planning diets in diseases of the intestines, upon which many diseases of the stomach, etc., are dependent, this method is ideal. For those who care to utilize the test diet for more information, much can be gained. It furnishes data relative to the stomach, pancreas, liver and biliary ducts.

In cases where marked putrefaction in the intestine exists, the examination for indican in the urine is helpful. In fact, this procedure is too often neglected.

Excessive indicanuria invariably runs parallel with intestinal putrefaction, and is a good index as to the severity of the putrefaction.

I agree with Bassler that the constant absorption of indol from the intestine is conducive toward weakening of unstripped muscle. Therefore, in gastropstosis, gastric atony, etc., the intestinal toxemia must be overcome before results can be expected. Unless the clinician has an index, such as the estimation of putrefaction, indican, etc., his efforts are most often in vain. Diet is the greatest factor toward correcting the condition.

Having given you some concrete examples of the im-



portance of diet, let me emphasize some of the essentials the general practitioner should know.

He should be familiar with fate and behavior of proteins, carbohydrates and fats in the alimentary canal.

About the average amount of protein, carbohydrate and fats required daily by a person at rest, doing light or laborious work.

The types of food that continue the flow of gastric juice or increase its acidity.

Those that suppress the flow of gastric juice or bind its acid content.

The length of time it takes certain foods to leave the stomach.

What is the caloric value of an ounce or more of the every-day foods, such as milk, eggs, butter, cereals, etc.?

That to sustain the average adult on milk alone, it would take approximately three quarts daily. This being too bulky and most often contraindicated, that he must reinforce smaller amount with cream, lactose, etc., or the patient will lose weight, etc.

He should know the foods containing fat soluble A and water soluble B—so-called vitamins.

In conclusion, let me say:

I have presented this paper in the hope that it will stimulate your interest in a subject that even the lay press recognizes to be important, evidenced by the many articles published on dietetics. I do not want to convey the impression that diet is the hub around which all therapeutics revolve; yet, when the indicated remedy is so often blamed for not doing its work, or a well indicated surgical operation robbed of its just reward, the importance of diet must be emphasized.

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DECAPSULATION OF THE KIDNEY.—W. G. Spencer (*Med. Science*, May, 1920) considers this operation useless in the chronic interstitial nephritis of adults, but states that it has succeeded in subacute parenchymatous nephritis, even when anasarca and ascites were present. The operation should be resorted to immediately, if improvement does not ensue soon as the result of medical treatment. It is best to decapsulate both kidneys at one operation. The author states that anuria may occur from infections in kidneys that were previously sound, and warns against performing this operation in such cases. Either nephrotomy or nephrectomy should be done.

**FORTY YEARS' EXPERIENCE WITH ACONITE.**

BY

S. W. S. DINSMORE, M.D., SHARPSBURG, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, Sept. 21, 1920.)

My attention was called to aconite by my preceptor very soon after I entered the study of medicine. In the good old days of the 70's it was customary for the young man to begin the study of medicine in the office of the doctor of his choice, and, if the doctor was a good homœopath and a student of materia medica, then one learned at least the keynote symptoms of the most frequently used drugs, before entering medical college.

Aconite was the first bottle in the first row, and the cork showed evidence of frequent use, and why not? Sudden rise of temperature, after exposure to wind and weather, with red face, restlessness and frequent short dry cough, was just as plentiful then as now, and we obtained fine results from prescribing aconite. Fear was a frequent accompaniment of the usual aconite symptoms and fear is often contagious. The parents or friends of the patient are alarmed at the sudden and severe onset of the symptoms. Chill, dry skin, thirst, restlessness, and sometimes delirium, constitute the symptoms most frequently presented, especially in the fall and spring of the year, and are most frequently allayed by a few doses of aconite. Shortly we find our patient sleeping soundly, and bathed in perspiration, and when he awakes is in his right mind, and verily we have our reward.

The congested condition with arterial tension is the sign-board that leads us to a further study of this, the keystone of the arch upholding the doctor in acute febrile conditions. "As it was in the beginning, is now, and will be." It surely is the lamp to guide us in our everyday practice, for the family physician deals most frequently with the beginning of disease, the specialist with the second and third stages, and, while it might appear that the family physician was slipping from his pedestal, yet the acutely ill, like the poor, we always have with us, and that portion whose onset is sudden, with high fever, restlessness, flushed face, thirst and fear of what is to come, will in the future, as they always have in the past, yield

at least temporarily to aconite. Thus will be afforded time to make a more extended examination and under less strain. Indeed, in many instances, it will be the only remedy required in the case.

Recently a man came to me complaining of this single symptom—a sensation as if a few drops of water trickled down his thighs. He was a railroad engineer, fat, flushed from contact with heat. His red face and restlessness (he was out and in the chair three or four times during his office visit), caused me to think of my old friend, aconite. I gave it to him in the third attenuation on tablets; result, entire disappearance of the symptom. A thankful patient, and a due reward! Could I have done better?

If so, with what other drug? I love old friends, old associates and now, as I am traveling down the western slope, why not say what is in my heart, the truth wherever it may be found. That is why for over forty years I have tried to adhere to the law of *similia similibus curantur*.

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### **SOME UNUSUAL PHENOMENA ATTENDING THE USE OF HOMATROPINE AS A CYCLOPLEGIC.**

BY

JOSEPH V. F. CLAY, M.D., F.A.C.S.

(Read before the Clinico-Pathologic Society, October 7, 1920.)

HOMATROPINE HYDROBROMATE is a much-used drug in the practice of ophthalmology, and, judging from personal experiences and the few reports to the contrary, its use, as a cycloplegic, is seldom attended by marked systemic manifestations. It is a rapidly acting drug. After the instillation of several drops of a four grain to the ounce solution, mydriasis occurs in from 10 to 20 minutes, and cycloplegia in from 60 to 90 minutes. Complete recovery after withdrawal of the agent occurs in from 36 to 48 hours. This fleeting action upon the ciliary muscle renders it a valuable agent in the correction of refractive errors.

Because of the very unusual manifestations in a recent case we feel that a citation of the symptoms may prove interesting.



Mr. H. G. P., age 37 years, reported August 23, 1920, for refraction. He could not recall whether he had had "drops" used in former examination which was made five years ago. Preliminary examination revealed no contraindication to the exhibition of a cycloplegic. One drop of a 4 grain solution to the ounce was instilled in each conjunctival sac. Fifteen minutes later a second drop was instilled. A few minutes later the patient stated that he felt "queer" and asked that he might bathe his face in cold water. He was permitted to do this but became faint and was assisted to a couch. He immediately lost consciousness, the face was ashen, the hands cold and clammy, the pulse slow and the musculature completely relaxed. Within a very short space, probably half minute, the pulse became imperceptible, and respirations were suspended, the eye balls fixed in the median position, the pupils dilated (local action of the drug), the cornea insensitive. While hypodermic medication was being prepared artificial respiration was attempted. This act was attended by a tonic spasm of the entire body and only after most strenuous action were we able to perform the necessary manipulations. In a very few seconds the chest muscles relaxed. The pulse returned, very feeble and irregular. The surface of the body remained cold. Consciousness returned and he was able to swallow a half ounce of dilute spiritus frumenti. This was repeated in fifteen minutes. The heart action now became much improved. Marked diaphoresis occurred and shortly emesis. In three hours' time conditions were much improved, but we noted marked facial twitching. The following morning the patient reported to me apparently none the worse for the experience.

In an experience of over twelve years, using this agent daily I have never seen symptoms of this nature from homatropine. Flushing of the face, dryness of the throat, intense thirst, facial twitchings, intense headache, nausea, rapid pulse have all been observed. Works upon pharmacology and toxicology state that the systemic effect of homatropine is similar to that of atropine except, as one author states, that while atropine accelerates the heart action, homatropine slows the heart. Atropine produces dryness of the throat, difficulty in swallowing, flushing of the face, while about the angles of the mouth a pallor is observed. The skin is generally hot and dry and the body temperature raised. Its action upon the brain

causes a marked delirium. The pulse is running and rapid and the respirations quickened. An analysis of the symptoms produced in my patient were practically the opposite.

After the storm the first thought was the solution used—homatropine—and was it the usual solution? It was the same solution we had used the day before and furthermore was used in subsequent cases without the slightest unusual manifestation.

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### FEVER OF OBSCURE ORIGIN IN CHILDREN.

BY

C. S. RAUE, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of New Jersey, May 29, 1920.)

IN infancy there is normally a striking uniformity in the body temperature, diurnal variations being slight and the normal standard being so consistently present that a "monothermia" is typical at this time of life. Artificially fed infants are, however, prone to show slight temperature irregularities and febrile disturbances, due to dyspeptic conditions. It has been shown that the sugar in the food is chiefly responsible for these temperature curves, although the salts in the food may also upset the infant's heat-controlling mechanism. The so-called "salt fever," observed in infants after the injection of normal salt solution has been proven to be due, not to the salt, but to the use of stale distilled water and is, therefore, either of bacterial or protein origin.

In older children the heat mechanism is very readily disturbed and we, therefore, frequently encounter transient rises of temperature due to some trivial cause. Furthermore, continued fevers, sometimes of considerable elevation, and of great stubbornness in duration are of common occurrence, and not only give us concern as to their significance but also baffle us in every attempt to find their cause. These obscure elevations of temperature are at times very trying to both physician and parents. While the cause of some of these fevers is never discovered and they eventually clear up without sequelæ and leave us in the humiliating position of labeling them "idiopathic," nevertheless, the majority are diagnosticable. Let us, therefore, review the various causes of fever in childhood, and

consider seriatim the more obscure clinical types of febrile disturbances.

**TUBERCULOSIS.**—A persistent evening rise in temperature, not high, and in accord with Koch's dictum that the temperature in a purely tubercular condition does not go over 100.4, higher fever indicating a mixed infection, is very strongly suggestive of tuberculosis. This symptom alone is not, however, sufficient basis for making a diagnosis of tuberculosis. Such temperatures may proceed from other causes, notably from infected tonsils and teeth. The diagnosis of tuberculosis will rest upon a definite history of exposure to tubercular infection; pallor and progressive loss of weight; persistent cough; a positive d'Espine sign and von Pirquet reaction and persistent rales in one or both upper lobes. Pulmonary tuberculosis is comparatively rare in children between 4 and 12 years of age; however, tracheo-bronchial gland tuberculosis is not uncommon and should always be considered in any case of persistent fever. Tuberculosis of the superficial lymphatic glands and tuberculosis of the bones, peritoneum as well as tubercular meningitis should offer no difficulty in their recognition.

**RHEUMATISM.**—Rheumatic fever in children is often so conspicuously lacking in joint manifestations that it may present diagnostic difficulties. It is not uncommon to find a child running a slight temperature for days with no other accompanying symptoms than lassitude, loss of appetite, vague aches and pains in the extremities, perhaps some skin manifestations, and no thought of rheumatism enters our minds until a cardiac murmur is discovered or the child eventually develops a full-fledged attack of chorea. Closer study of such a case will reveal the fact that there have been previous attacks of sore throat and that the tonsils are diseased, or decayed teeth may be discovered. Recurring sore throat and "growing pains," especially when associated with a slight febrile reaction, should always arouse our suspicions of rheumatism, and in such cases the heart should be carefully watched and systematically examined.

**PYELITIS.**—Persistent high temperatures in infancy, which cannot be accounted for after the chest, gastrointestinal tract, ears, nose and throat have been examined and have been found negative, should always lead us to suspect pyelitis. Pyelitis is far more common than is generally supposed; it is easy



to diagnose and comes under the category of diagnostic errors of omission rather than of ignorance. The supposed difficulty of obtaining a specimen of urine from an infant is largely responsible for the many failures to diagnose pyelitis early. There is less excuse for not examining an infant's urine than for a failure to make a blood examination and yet the latter is perhaps less frequently neglected than the former. It is true, a single specimen of urine may not be sufficient for a positive diagnosis as pus and bacteria may at times be absent from the urine, but if the symptoms are suggestive of a pyelitis, we should make repeated examinations until we have made certain.

**EMPHYEMA.**—Small accumulations of pus in the pleural cavity following pneumonia, especially if they are encysted or situated in unusual localities, such as inter-lobar empyemas or accumulations of pus between the diaphragm and lung, frequently escape detection or present the greatest difficulties at locating the same. A continued fever following an attack of pneumonia, especially if there is a leucocytosis present and a septic type of temperature, should always arouse a suspicion of empyema. The physical signs of empyema are often indefinite and misleading. Dulness and bronchial breathing over the lower part of the chest, or in the axillary region, is by far more likely to signify an accumulation of pus than an unresolved pneumonia or a tubercular infiltration in a child. Bronchial breathing is, indeed, quite characteristic of a pleural effusion in childhood. Pulmonary consolidation is differentiated by the presence of dulness instead of flatness and by increased instead of diminished vocal fremitus. Furthermore, delayed resolution of a pneumonic consolidation never persists for the length of time observed in empyema. In all doubtful cases aspiration under strict asepsis should be resorted to.

**INTESTINAL TOXEMIA.**—Iliac stasis with the absorption of the products of intestinal putrefaction is far more likely to induce fever in children than in adults and is a common cause of febrile attacks. With these attacks there is usually associated coated tongue, foul breath, anorexia, headache, malaise. The urine is concentrated and high colored and contains an excess of indican. The bowels are constipated. The child sleeps poorly, grits its teeth during sleep and frequently there are night terrors. Worms undoubtedly produce these symptoms at times and in all such patients it is advisable to

begin treatment with a preliminary course of *santonin* and *calomel*.

Some of these cases do not respond to the usual treatment and blood examination shows a slight leucocytosis. There is more or less constant digestive disturbance; the child shows signs of malnutrition and there is tenderness over the colon or in the region of the appendix. A diagnosis of chronic appendicitis is frequently made. An infection of the colon and not only colonic stasis is the true pathologic condition in these cases. Irrigation of the colon in conjunction with diet and the administration of an autogenous vaccine prepared from the stool are indicated.

THE ROLE OF PROTEIN POISON IN THE ETIOLOGY OF FEVER.—The work of Vaughn on split proteins and protein poisons has thrown new light upon the subject of fevers. Vaughn has shown that there is a protein poison which exists as a constituent of every protein molecule and which, under certain conditions, is split off from proteins either in the intestinal tract or in the blood stream, and thus induces the symptoms of infection. This is the case with many bacterial infections, for example, typhoid infection. The typhoid bacilli themselves in the ordinary state do not induce the symptoms of fever and toxemia. They enter the blood stream and during the first ten days or period of incubation, no symptoms are present. At the end of this time, however, the body cells have succeeded in elaborating sufficient ferment to destroy the invading foreign protein, or bacillus. A parenteral digestion of the bacilli takes place, the toxic protein substance is liberated and the fever and toxemia begin.

Similarly, through the incomplete digestion of ordinary food proteins in the intestinal tract the toxic radical of the protein molecule may be liberated and a febrile attack result. Vaughn has shown that proteins are most poisonous at the peptone stage of digestion. Protein absorbed into the circulation at the peptone stage is, therefore, capable of producing a toxic reaction.

**THE MANY PHASES OF ASTHMA: ETIOLOGIC AND THERAPEUTIC.**

BY

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(Read before the New Jersey State Homœopathic Medical Society, May 29, 1920, and before the Interstate Homœopathic Medical Society, Oct. 28, 1920.)

IT is not necessary to apologize for my subject, nor to explain its importance. Your chairman decreed with the suavity for which he is famous that I should address you concerning some phases of asthma. I must confess, however, that in so doing he had named a theme which has always had for me a remarkable interest. Quite naturally I admired his good judgment, and was by no means unwilling to accede to his request. Asthma most assuredly offers many opportunities for differences of opinion, and there is scarcely one of us who has not been worried sick by its vagaries.

Symptomatically and diagnostically, there is but little opportunity for discussion. The clinical course of asthmatic seizures with the intervening periods of relatively good health, is well known to all. The important points in this connection being that we shall restrict the study of asthma to the type of paroxysmal dyspnoea which we are accustomed to designate as bronchial asthma. Paroxysmal dyspnoea, due to renal, cardiac, and other causes, should be designated "renal dyspnoea," "cardiac dyspnoea," etc., etc., through the list.

Until within a very few years back, many facts bearing on the etiology of asthma had been noted and recorded in our text books. As mere statements of facts, they remain to this day undisputed. Unfortunately, they were of but little practical value in most instances, because they constituted a mere jumble of information without any logical association. In consequence, profession and laity alike have been subjected to the wildest possible therapeutic schemes for the relief of the disease. Charlatans, never slow to grasp an opportunity when the medical profession has confessed itself helpless, have seized upon the occasion, with the result of making bronchial asthma the most "quacked" of the "quackable diseases." Thus much harm has been done the helpless victims. It is my experience to meet patients, sufferers from this disease for a



number of years, who to date had never exhibited sufficient confidence in the medical profession to consult a legitimate practitioner of medicine.

That asthma has important neurotic and gouty relationships is admitted by all. We should not, however, make these "the" causative factors. Very few asthmatic patients fail to become neurotic. If careful history taking was the rule, very few would be found to have been neurotic from the inception of the illness. Suffering, environment, and false therapeutic gods, unite to add nervous complications to what was originally a simple symptomatology.

The cases in which asthma has appeared on a gouty foundation are relatively few in number, but nevertheless, they are not disputable. In most of them, the gouty habit is hereditary. In practically all instances, the victims are children.

Sometimes, asthma has exhibited an hereditary origin. Such heredity may be direct from parent to child, the latter being stricken at approximately the same age as the former, and curiously the disease disappearing at about the same age in each. It has even been known to pass through several generations of a family.

No age is exempt. Asthma has occasionally attacked infants. A very large proportion of the cases have their inception in childhood. Many of these have made excellent recoveries at puberty without any reasonable explanation, the last medical attendant carrying off all the therapeutic glory. Another large percentage of cases makes its first appearance between adolescence and young adult life. Very few instances are observed in which the initial seizure comes on after the age of 50 years. Indeed, such a period of onset is almost sufficient reason for throwing doubt on a diagnosis of bronchial asthma. There are, it is true, a certain number of cases in which the clinical history of the illness presents certain puzzling similarities to that disease, but careful analysis determines the presence of complications, as chronic bronchitis, etc.

Most statistics favor the predisposition of the male sex, and especially so in cases occurring for the first time in early adult life. The gouty constitution and habits of living have been brought forward to explain this.

A study of the etiologic relations of climate and asthma gives most puzzling and contradictory results. Absolutely no

rules can be formulated. Some patients are worse during the months between spring and autumn, alleging their illness at such times to be due to inhalation of pollens, etc.; while others, and these, in my experience, are unquestionably in the majority, are worse in the winter and late early spring. Some patients are better in dry weather; and some during the rainy season. Some thrive in foggy climates; others in the sunshine. Some are well at the seashore, while others are made worse thereby. Some do well in the city, and are attacked only when in the country. It has even been alleged that the mere atmospheric change incidental to a residence in the third or fourth floor of a building is sufficient to make the difference between health and invalidism. In other words, the clinical study of each case of asthma is not unlikely to bring out points directly contradicting one's experience in what might be described as "an exactly similar case."

A line of causes that has quite properly received considerable attention is that related to the nasal mucous membrane. It must be admitted that there are many instances in which the removal of adenoids, enlarged tonsils, intranasal hypertrophies, etc., have accomplished wonders, and it must also be admitted that recovery has not ensued by any manner of means in every case in which these operations have been performed. Our assumption of knowledge should stop with the above statement. Instead there is a strong disposition on the part of some rhinologists to assume that the naso-pharyngeal cause is always the cause, and that failure to cure simply means lack of surgical thoroughness. The result is that some old asthmatic patients finally come to the internist uncured, and with nasal passages and nasal pharynx trimmed of about everything removable, nothing remaining excepting two holes in the face.

A peculiarity of asthma in its relation to the lungs is that it occurs almost exclusively in persons with healthy pulmonary structure; and that when the lungs themselves become inflamed, the asthmatic paroxysms not infrequently disappear for the time being. This statement must not be accepted as having universal application. One of my cases who had been free of paroxysms for a number of years, was taken simultaneously with a return of the asthma and a bronchopneumonia, since which time the asthma has been as persistent as ever.

It is also alleged that asthmatic patients seldom become tuberculous.

Five of my asthmatic patients were the victims of pneumonia. In each the asthma had been of long standing, and the pneumonic condition was severe if we accept purely clinical phenomena; and yet all recovered.

It is doubtful if disease of the stomach *per se* is ever a cause of asthma. I have seen a number of patients who alleged "indigestion" as the cause. The latter term is at the best a vague one, which may cover about anything in the way of discomfort at or below the waist line. Many of the individuals thus affected were neurotic, and it is more than probable that much of the asthma attributable to a gastric origin in reality may have had a nervous foundation based upon environment and habits. On the other hand we do know that there are some patients who suffer from attacks as the result of dietetic indiscretions or by reason of an idiosyncrasy to certain foods. The latter peculiarity, though frequently observed in practice, and noted in literature for many years back, has never received the attention its importance warrants until the anaphylactic origin of asthma came into prominence.

Constipation and flatulence are alleged to be exciting causes of paroxysms.

The possibility of a focus of irritation existing in the teeth, ears, eyes, genital organs, and other portions of the body must be considered; although as a matter of fact, cases of this kind are clinical curiosities; but they do appear with sufficient frequency to force us to be on guard lest they escape attention.

Once upon a time we finished a disquisition on the etiology of asthma by saying that the psychic factor is unquestionably predominant in some persons. And to prove this point, it was stated that asthma was produced in some persons by the presence of certain animals, as cats, horses, deer, etc. But numerous physicians well acquainted with the peculiarities of their patients and who are not likely to be deceived by hysterical vagaries, have testified to the authenticity of cat asthma. Walker and others have proven the possibility of producing the disease by exposure to horse hair protein. Recent research would seem to point to the probability that the "animal asthmas" are the result of anaphylaxis. For years we have been painfully aware of the danger of serum administration to persons the victims of bronchial asthma.



One point concerning the symptomatology of asthma is the frequently associated eosinophilia, and I have always felt that when this phenomenon is explained, we shall be able to solve all etiologic incongruities.

Such an explanation seems now at hand. We have long noted the association of asthma and hay fever in the same subject, both idiopathically and by way of heredity. Within a few years, a number of investigators have shown apparently that hay fever and asthma may be due to sensitization to certain proteins, which may be derived from pollens, food stuffs, bacteria, etc. There is a large group of cases in which the symptoms appear at a definite season of the year, oftentimes corresponding closely with the hay fever periods. The investigation of Walker and others appear to prove that these facts may be utilized therapeutically. The subject is altogether too new to enable us to speak concerning it in a dogmatic manner. This subject, however, is receiving more and more attention. Unfortunately in our studies we are too apt to look for effects following immediately upon some hypothetical cause. This quite naturally brings us nowhere excepting in a certain few instances. If we study things more deeply and investigate the sensitiveness of asthmatic subjects to certain proteins, we are likely to build up information on etiologic lines, and at the same time we are paving the way for a radical cure.

The treatment of asthma is one of attention to details. Success is obtainable only if the physician is in every sense an artist, who, in addition to his ability to exhibit himself as a master of clinical examinations and history taking, is capable of arranging the different components (the symptoms and signs) thereof to make the true clinical picture with each object placed in its proper relationship to the whole, *i. e.*, central object, distance and foreground. The patient requires as much consideration as does the disease. Although asthma is not to be regarded as a nervous disease, nevertheless the nervous element is of great importance in the management, for this self-same temperament goes a great way in following out systematically the instructions of the attendant. It also plays an important part in influencing the physician in laying his therapeutic plans. So far as possible, the etiological factors must be considered, although it must be admitted that much of what the patient has to say on this subject must be taken *cum grano salus*.

Some cases that are greatly depreciated constitutionally demand prolonged course of rest treatment after the method of Weir Mitchell. The main element to be enforced rigidly is the rest in bed and over-feeding. The isolation, while of value is not to be recommended, excepting when the patient possesses meddlesome relatives, and he himself, of a highly neurotic constitution and impressionable to unwise suggestions.

The remedies which are useful for palliating the seizures can seldom be used for any extending period of time without doing the patient permanent harm. As Goodhart remarked, "The treatment of asthma becomes too often a repeated sacrifice to the paroxysm," and that the palliative campaign is ultimately most disastrous. Notwithstanding the truth of Goodhart's assertion, it happens that there are cases, the minority, it is true, in which from one cause or another, the palliative seems to be absolutely necessary. When such occurs, it impresses me as the wiser plan to yield to the inevitable, and obtain the patient's confidence that we may ultimately direct him to a course promising more permanent results.

Concerning these palliatives, I will not speak *in extenso*, but will refer to some of the uncertainties of a certain class of favorite remedies. Several years ago there happened to be in my wards a patient undergoing a typical asthmatic seizure. I administered 3 drops of amyl nitrite by inhalation, and complete comfort was secured within a few minutes. I have tried the remedy a number of times since then, but never with such dramatic success. I have had one similar result from adrenalin, and have examined a patient whose seizures were always relieved by this remedy. In another case, remarkable relief was obtained by the administration of suprarenal extract by the mouth. An English physician is a strong advocate of pituitary substance, and claims to have given permanent relief to six cases by it.

When it comes to curative treatment, I feel sure that my hearers can let loose the flood of therapeutic romance rivalling the fiction of old. We hear of cases cured by correcting refractive errors, by graduated tenotomies of the eye muscles, by divulsion of the sphincter ani, by correction of spinal misplacements or displacements, and by nasal and pharyngeal operations unmentionable and innumerable. Now I would not for one instant depreciate neglect of any defect in an asthmatic

subject, but the matter has been run into the ground. These various means of cure (?) are, as a rule, tried out, not because the therapist differentiates his cases, but because he happens to be a firm believer in this or that particular line of work, or is a specialist in some special branch of medicine. Really, the career of the poor asthmatic, as he goes the rounds, reminds me very much of the hero in that interesting medical novel, "Being Done Good." Really, the situation is a blot on the reputation of medicine.

I believe that the nose and throat should have a routine thorough examination in every case, and that all abnormalities should be corrected. But I do not believe that the patient should pass from rhinologist to rhinologist, each one trying to go one better on the procedures of his predecessor. We should remember that every asthmatic does not have nasopharyngeal disease, and there are many cases of nasopharyngeal disease without any associated asthma.

I have often thought that asthma is much like epilepsy in one respect, namely, the relief following operation *per se*.

Recent researches seem to place the dietetic management in an important light. Walker's cases seem to prove that about 56 per cent. of the cases are sensitive to food proteins, though notably those of wheat, eggs and fish. Such cases yield after a time if the offending articles of diet are banished from the patient's tray.

Climatic treatment is largely experimental. One can never tell in advance just how the patient will react to a change.

Of the remedies for asthma, I have nothing new to offer. My favorable experiences have been with kali bichromicum, atropia, belladonna and potassium iodide, with an occasional instance in which improvement was secured by nux vomica or arsenicum. Of late years, I have placed more and more faith in kali bichromicum with atropia a close second.

As to treatment based upon the newer theories, I have had but little experience, and that in the line of dietetic restriction. The treatment by desentization sounds reasonable and is worthy of trying out. It requires time, however, and both physician and patient must be possessed of patience.



## INFANTILE ECLAMPSIA.

BY

CHARLES H. SEYBERT, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Philadelphia County.)

INFANTILE ECLAMPSIA is one of the more frequently seen nervous manifestations of early life concerning whose etiology there is considerable doubt. The many theories advanced in explanation of the immediate processes involved in the production of convulsions seem to be at variance. The cause of their frequent occurrence, however, is assumed to be due either to the peculiarity of the diseases to which children are subject and which differ from those of adults, or to peculiarities of the infant organism and nervous system.

By reason of the imperfect development of the inhibitory centres and because of the increased reflex irritability seen at this period, any slight stimulus applied either directly to the motor area of the brain or reflexly from some other part of the body may prove a causative factor.

There are no characteristic lesions of eclampsia; those found are very variable and dependent upon the causation. The changes occurring in the brain are probably anemic with a secondary cerebral hyperemia.

ETIOLOGY.—The causes of eclampsia may be divided into predisposing and exciting.

*Predisposing.*—Heredity may exert some influence. A child, however, cannot inherit convulsions, but it may inherit a predisposition, for it is a well-known fact that in children of some families the least exciting cause will induce convulsions, while in others the same source of irritation has no apparent affect. This can be explained only upon the supposition that children are born with the convulsive or spasmophilic tendency. By the term spasmophilic tendency or diathesis is meant a pathological predisposition to certain partial or general tonic and clonic convulsions, usually found in children of nervous, alcoholic, syphilitic or tuberculous parentage and manifesting itself in such functional spasmodic affections as infantile eclampsia, tetany, pseudo-tetanus and spasm of the glottis.

Children suffering from rickets are very prone to convulsions, especially that form known as laryngismus stridulus,

the "inward spasms" of the mother. Other disorders showing nutritional disturbance such as anemia, syphilis or malnutrition from any source likewise predispose.

*Exciting.*—Among the exciting causes reflex irritation is a very fertile one; in this class may be mentioned difficult dentition, presence of undigested food in the stomach or intestinal tract, phimosis, retention of urine, worms and trauma.

\* Difficult dentition while capable of causing convulsions does not play the important role in its etiology as is supposed by the public and many of the medical profession as well. Irregular and delayed dentition is often nothing but another sign of rachitic tendency and it is this which is more likely to be the predisposing cause, although an inflamed and tender gum may precipitate a paroxysm.

The question sometimes arises whether convulsions resulting from the presence of undigested food in the alimentary tract are the result of reflex irritation or of auto-intoxication as the severity of the symptoms oftentimes lead us to believe.

The acute infectious diseases are frequently ushered in by convulsions instead of chills, especially is this true of scarlatina and pneumonia; the exciting cause in all probability being due to the influence of the poison peculiar to the disease. Convulsions occurring later on in the course of infectious disorders may be dependent upon hyperpyrexia or some other toxic influence, *e. g.*, uremia in scarlet fever. In pertussis, eclampsia, which is especially liable to occur, may be the result of asphyxia, cerebral hemorrhage or exhaustion. Other toxic causes may be found in hereditary syphilis, asphyxia, especially of the new-born and as a result of some metallic or vegetable poison, *e. g.*, lead, opium or strychnia.

Sudden anemia from severe loss of blood and venous stasis accompanying diseases of the heart and lungs may become etiological factors through the interference with cerebral circulation.

Lastly, convulsions may originate in diseases or injury of the brain from direct cortical irritation; this is seen in meningitis, hydrocephalus, cerebral hemorrhage, abscess or thrombosis and brain tumor.

*SYMPTOMS.*—In the majority of cases the attack comes on abruptly without the slightest warning. Occasionally there may be prodromal symptoms, such as twitching of the mouth

and extremities, flexing of the thumbs into the palms of the hand, rolling upward of the eyes and restlessness. The first thing usually noticed is that the eyes become fixed. This is almost immediately followed by convulsive twitchings, local at first and extending rapidly till all parts of the body are involved; at times, however, when the cause is a localized organic lesion of the brain the convulsions may be unilateral or confined to a single extremity. The convulsive movements may consist of any variety of tonic and clonic spasm. The face is pale at first becoming cyanotic later; there is frothing at the mouth, the pulse weak and may be fast, slow or irregular, respiration is shallow and often spasmodic. In a true convulsion there is always complete loss of consciousness and there may be involuntary passage of urine or feces. At the end of the attack the convulsive movements become less frequent and finally cease altogether, usually leaving the patient in a condition of coma, after which the child soon passes into a more natural sleep and unless there be a recurrence, awakens bright and well. There may be only one attack or there may be recurrences at short intervals. Immediate recurrence is not common in spasmophilic and reflex convulsions, but is sometimes seen in those of organic origin or in certain forms of toxemia, especially that produced by absorption from the gastro intestinal tract.

The duration of the attack is very variable. In convulsions due to spasmophilia or associated with reflex causes, they rarely last more than 2 or 3 minutes. In convulsions due to organic brain lesions the attack often persists much longer—sometimes as long as half an hour or even more.

A transient paralysis due to exhaustion of the nerve centres is sometimes seen after a convulsion of purely functional origin; a point well worth remembering because a permanent paralysis following a convulsion usually means an organic lesion.

Death may occur in a convulsive attack, although comparatively rare, and when it does, is usually seen in young infants. While the cause of death may be asphyxia or exhaustion, some underlying factor such as "status lymphaticus" or tetany of the heart is often responsible.

DIAGNOSIS. —The recognition of a convulsive attack presents no difficulty. Far more important is the recognition of the cause of the occurrence, and in order to accomplish this a very



careful history of the patient and all the attending symptoms is required. A most careful and thorough physical examination also should be made.

Convulsions occurring in the early weeks of life may be due to some organic lesion as cerebral hemorrhage or defective cerebral development. Prolonged labor may give rise to eclampsia as a result of circulatory disturbance without the existence of any organic lesion. While spasmophilia as a cause can be excluded at this period, convulsions of toxic origin from gastro-intestinal derangement are a possibility. In the majority of cases, however, the cause at this age is organic.

Organic brain disease should be suspected when the convulsive attack is prolonged, the diagnosis depending mainly upon the presence of focal symptoms, such as localized spasm or paralysis, strabismus or changes in the pupil. Limitation of the convulsions to one side or to one extremity while strongly suggestive of an organic lesion is occasionally seen in purely functional disturbances. Convulsions as a result of an organic lesion of the brain are not accompanied by fever, except in acute meningitis, encephalitis and cerebral abscess. In cerebral hemorrhage and meningitis the attacks are liable to recur within a short time; in new growths they usually recur after a much longer period.

The commonest cause of convulsions in infancy and early childhood is spasmophilia and should always be suspected when there is no evidence of an organic lesion. The diagnosis depends upon the recognition of such signs as laryngo-spasm, carpo-pedal spasm, Chvostek's sign, peroneal reflex and Trousseau's sign. While the diagnosis of this condition is often impossible immediately following a convulsive attack, if careful examination be made on each of the successive days some one of the characteristic signs will usually be found if spasmophilia be present.

The most important fact to bear in mind in the recognition of acute infections as the cause of convulsion is the high temperature in the absence of any organic brain disease.

Uremia is a possible cause of eclampsia in early life and an examination of the urine should be made in all cases in which the origin of the convulsion is not clear.

Asphyxia is a cause of convulsions in the new born and

also late in the course of pneumonia, membranous laryngitis and pertussis.

In reflex cases of convulsions the possibility of spasmodophilia should always be borne in mind and the source of irritation looked upon merely as a precipitating factor.

The possibility of epilepsy should only be considered after all other causes have been excluded. In infancy idiopathic epilepsy is not probable, the condition being seen rarely before the age of three years and is recognized by the distinct aura preceding the attack, its short duration, non-remittent character and a history of previous attacks.

*Prognosis.*—The prognosis of infantile eclampsia depends entirely upon its cause; as a rule convulsions in themselves are rarely fatal excepting perhaps when they occur as a terminal condition of some recognized disease. Fatal attacks are mostly seen in the new born or very young infants in whom the cause is obscure. Death from asphyxia may occur in pertussis or late in the course of laryngeal or pulmonary disease. When convulsions are prolonged and oft repeated the outlook is very doubtful. In the majority of cases convulsions mean only a nervous hyper-irritability.

In those cases in which a convulsive habit becomes firmly established idiopathic epilepsy is very likely to develop.

*TREATMENT.*—During an attack the convulsions should be arrested as quickly as possible by means of inhalations of chloroform, ether or the hypodermic use of morphia. Should the attack last for a considerable length of time the immersion of the patient in a warm bath or a hot pack with cold applications to the head may help in controlling the spasms. As the convulsions subside the attention should be directed to the possible cause and therapeutic measures employed as indicated. Hyperpyrexia calls for the cold pack, sponge or tub bath. Gastroenteric derangement for emesis by either apomorphine hypodermically or ipecac by mouth, enteroclysis and suitable catharsis.

Nervous disturbance calls for hot baths with or without mustard, counter irritation to the spine and the possible use of bromides or chloral by rectum or mouth.

Lumbar puncture is indicated in all forms of cerebral irritation associated with increased intra-cranial pressure and may be employed when milder measures fail.

Homœopathically the most frequently indicated remedies in eclampsia are: *Bella.*, *cuprum*, *ignatia* and *mag. phos.*

With the cessation of the convulsions, treatment should be directed to the more remote etiologic factors; the general health should be improved and diet regulated; undue excitement should be avoided, rickets, if present, should be promptly attended to, faulty environment corrected, and all local irritations, *c. g.*, phimosis, adenoids, foreign bodies in ear or nose quickly removed.

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### SOME SCIENTIFIC ASPECTS OF COLD STORAGE.

BY

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*Contribution from the Constantine Hering Laboratory of the Hahnemann Medical  
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(Read before the Clinico-Pathologic Society of Philadelphia, October 7, 1920.)

FROM the viewpoint of bromatology, cold storage is the storage of perishable foodstuffs at a low temperature, which is almost invariably produced by mechanical refrigeration. Broadly speaking, cold storage may be divided into chill room or cooler storage, and freezer storage. The chill room or cooler has a temperature in the neighborhood of the freezing point of water. The temperature of the freezer lies below freezing, being as low as fifteen degrees below zero Centigrade, or five degrees below zero Fahrenheit. In the trade, the application of the term "cold storage" varies with the commodity, and the temperature at which it has been carried. For instance, shell eggs are kept in a cooler or egg room at a temperature of 29 degrees to 32 degrees F., and are designated "cold storage," while eggs which have been removed from the shell, placed in cans, and kept in the frozen condition are called "frozen eggs." Poultry and meat which have been carried for weeks in a cooler are sold as "fresh," while that which has been frozen solid and kept in that condition is termed "storage" even if the period of holding has been merely a few weeks.

The Act of the General Assembly of Pennsylvania, approved June 26, 1919, defines cold storage as "the storage or keeping of articles of food at or below a temperature of 40



degrees F. in a cold storage warehouse." A cold storage warehouse is defined as "any place artificially or mechanically cooled to or below a temperature of 40 degrees F. in which articles of food are placed and held for thirty days or more." The articles of food are enumerated as "fresh meat, and fresh meat products, and all fresh fish, game, poultry, eggs and butter." Any article of food which has been in cold storage for thirty or more days must be sold as "cold storage goods"; and the maximum permitted period of cold storage for beef, pork, sheep, lamb, veal, poultry, game, eggs, butter and fish is fixed at twelve months. Commodities, withdrawn from cold storage and placed on the market, may not be returned to cold storage. Diseased, tainted or otherwise unwholesome food may not be placed in cold storage.

The changes undergone by a foodstuff during cold storage may be divided into chemical, bacteriological, histological and organoleptic. The chemical changes may be subdivided into changes in the gross composition, the composition of the fat, and the partition of the nitrogen.

When poultry is held in a chill room at a temperature of 0 degree C. (32 degrees F.), for three weeks, the amino acid and basic nitrogen of the meat increases at the expense of the protein nitrogen; and an increase also occurs in the acidity of the fat. The bacterial content of both the muscles and the skin increases. The muscle fibers shrink or decrease in width, and become ruptured; and exudation of the cell contents occurs. The chemical changes during holding for three weeks in the chill room are approximately equal to those undergone during keeping in a household refrigerator at a temperature of 45 degrees to 55 degrees F. for a period of five to seven days, and are somewhat less than those occurring during holding in the room at an average temperature of 75 degrees F. for a period of two days.

During freezer storage, poultry undergoes a progressive desiccation of the muscular tissues. The amino acid and basic nitrogen content of these tissues increases at the expense of their protein nitrogen; this slow but distinct proteolysis is similar to that produced by the enzyme trypsin, and becomes more marked as the period of storage lengthens. The fat shows an increased acidity and certain other changes in composition. The chemical changes during storage in the freezer for one year at a temperature of 10 degrees to 15 degrees F.

are about equal to those during storage in the chill room for three weeks. The bacterial content of the flesh decreases, but the tissues do not become sterile during freezer storage. In fact, the chemical changes in the hard frozen chickens are due to the action of enzymes rather than to the activities of bacteria. The muscle cells undergo a progressive shrinkage or decrease in width. Muscle fibers with a ruptured sarcolemma and exuding cell contents increase in number as the period of storage lengthens; and definite changes occur in the histological structure of the muscles.

As to the organoleptic properties, chickens which have been kept in a chill room for three weeks remain fresh and in excellent condition, and are free from odor; the bloom is retained; skin and muscles have a normal appearance; and putrefaction is entirely absent. These birds are edible, and have not deteriorated in flavor; in fact, they have "ripened" to their improvement.

When chickens are properly killed and dressed, and enter the freezer in good condition, they may be kept there for a reasonable period of time—from one season of abundant production to the next—without appreciable deterioration. After thawing in dry air, the skin retains its clear fresh color and soft texture. At times, the flesh of the thighs and breast becomes very slightly deeper in color than in fresh poultry, but the change is negligible. The fat deepens slightly in color, and may be characterized by a faintly rancid odor and taste. At about the sixth month of holding, a trained observer notes a slight difference in taste between the flesh of a hard frozen or cold storage chicken and that of a fresh bird. This difference in taste is still slight up to and including nine months of storage, and is scarcely of more than scientific interest. After nine months, the flesh is still wholesome and nutritious, but a distinct loss in flavor has occurred. After chickens have been kept in freezer storage for several years, their fat responds to the test for aldehydes; and compounds of this type possibly are the cause of the rancid flavor.

Statistics, based on the year March, 1909, to February, 1910, both months included, show that, of the poultry received by warehouses for cold storage, 22.5 per cent. was held less than one month, and but 6 per cent. was held for more than six months. Economic law requires that the perishables, which represent an investment, and have also been subjected to

storage charges, must be sold before they are compelled to compete in the market with the fresh crop of the next season. It is of interest to note that the changes reported above become most marked after the normal storage period of commercial practice has been passed.

A few figures may be given to show the part played by cold storage in preserving perishable foods from the season of plenty until the period of scanty production. Statistics for the Continental United States record that 63,495,687 pounds of frozen poultry were in storage on January 1, 1918, and that 403 cold storage warehouses contained 6,602,711 cases of shell eggs of 30 dozen each on August 1, 1917.

Experiments under commercial conditions have demonstrated that the deterioration during marketing is not more rapid in chickens, which have been stored in the freezer for nine months, than in fresh, promptly marketed birds.

The mode of thawing of hard frozen poultry is a matter of importance. To obtain the most satisfactory product, the carcass should be permitted to thaw in cool air, *e. g.*, in a refrigerator. If thawed in water, a considerable portion of the flavor is lost; and decomposition is facilitated.

Cold stored shell eggs are frequently a subject of discussion. Chemically, the changes, during holding, in eggs, which enter storage in good condition, are merely of academic interest. A shrinkage in volume of the contents of the shell occurs, due to desiccation; and the air space grows larger as a result. Moisture also passes from the white into the yolk. Eggs which have been properly graded and cold stored are good food at the end of nine months, although they may not soft boil or poach satisfactorily. The ability to soft boil is retained for six or seven months if the eggs be strictly fresh on entering storage. The so-called cold storage flavor is a foreign flavor absorbed by the eggs during storage, probably from the strawboard flats and fillers.

Prior to cold storage, fish are usually dipped several times into a tank of clear, clean water, in a room which has a temperature of 20 degrees to 25 degrees F. The fish are thus provided with a glaze, or air-tight protective envelope of clear ice, which aids in their preservation. The glazed fish are usually stored at a temperature ranging from zero to 10 degrees F., occasionally at a temperature ranging from 5 degrees below zero to 5 degrees above zero F. The average period



of storage is approximately eight months. Reglazing is necessary if the fish be stored for more than three to five months. Bluefish and weakfish, which had been glazed and cold-stored for periods of sixteen months and thirteen months respectively, remained palatable and wholesome. When these species of fish were kept in storage for two years, they were no longer palatable. During storage, certain changes occurred in the partition of the nitrogen of the flesh, and in the composition of the fat.

Cold storage merely reduces the normal changes in perishable foodstuffs to a minimum. If an article of food has been in cold storage, and is found to be in bad condition, its condition is to be attributed, in all likelihood, to bad handling either before entry into or after withdrawal from storage and not to cold storage.

In conclusion, it should be remembered that cold storage performs a legitimate function; it carries over perishables from the season of maximum production to the period of non-production and scarcity, and thereby increases the supply of foodstuffs at seasons when food would otherwise be available in insufficient quantities to meet the demands of the people.

#### BIBLIOGRAPHY.

Pennington—Studies of Poultry from the Farm to the Consumer. U. S. Department of Agriculture, Bureau of Chemistry, Circular No. 64, 42 pages (1910).

Hepburn—The Handling, Transportation, and Storage of Perishable Foodstuffs. *Journal of the Franklin Institute*, 1911, CLXXI, 585-598; 1911, CLXXII, 173-193.

Hepburn—The Oxidation of Chicken Fat by Means of Hydrogen Peroxide. U. S. Department of Agriculture, Bureau of Chemistry Circular No. 75, 8-1 (1911); *Journal of the American Chemical Society*, 1912, XXXIV, 218-222.

Holmes—Cold Storage Business Features, Reports of Warehouses. U. S. Department of Agriculture, Bureau of Statistics Bulletin 93, page 34 (1913).

Pennington—Hepburn, St. John, and Witmer. The Influence of Temperatures above Freezing on the Changes in Chemical Composition, Bacterial Content, and Histological Structure of the Flesh of the Common Fowl. *Journal of Biological Chemistry*, 1917, XXIX, pp. XXXI-XXXII.

Pennington—Hepburn, St. John, and Witmer. The Influence of Temperatures below Freezing on the Changes in Chemical Composition, Bacterial Content, and Histological Structure of the Flesh of the Common Fowl. *Journal of Biological Chemistry*, 1917, XXIX, pp. XXXIII-XXXIV.

Clark and Almy—The Commercial Freezing and Storing of Fish.

U. S. Department of Agriculture Bulletin No. 635 (Department Series), 9 pages (1918).

Bell—Cold Storage Reports, Season 1917-1918. U. S. Department of Agriculture Bulletin No. 776 (Departmental Series), pp. 18, 34 (1919).

Jenkins—Commercial Preservation of Eggs by Cold Storage. U. S. Department of Agriculture Bulletin No. 775 (Departmental Series), p. 33 (1919).

Cold Storage Legislation—Hearings before the Committee on Agriculture, House of Representatives, Sixty-sixth Congress, First Session, on Cold Storage Legislation, 1919.

Jenkins, Hepburn, Swan and Sherwood—Effects of Cold Storage on Shell Eggs. Ice and Refrigeration, 1920, LVIII, 140-147.

Clark and Almy—A Chemical Study of Frozen Fish in Storage for Short and Long Periods. Journal of Industrial and Engineering Chemistry, 1920, XII, 656-663.

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### SCROTECTOMY.

BY

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(Read before the Homœopathic Medical Society of Delaware, Chester and Montgomery Counties (Pa.), October 12, 1920.)

It is a difficult thing for those of us who are situated in a small town to find clinical material in sufficient quantities to produce anything for your consideration that might be out of the beaten path, and hence, the preparation of a paper on a surgical subject that will be of more than a passing interest to you is difficult, to say the least. However, having received the order from our President to prepare such a paper for this meeting, I am going to try to describe to you an operation which I first saw performed while in the service and which may be new to most of you.

Among the enlisted men in the late war, there were many who suffered with varicocele to a greater or lesser degree, and many who had merely a remarkably redundant scrotum. For obvious reasons these conditions impeded them severely in the performance of the duties required of the soldier.

Various operations of scrotoectomy have been devised for the relief of these conditions, and all have been more or less effective. Warbasse transfixes the redundant tissue transversely and, after placing a row of interrupted, and through sutures below his transfixation level, amputates the redundant tissue,

rounds off the corners, and closes the skin surface with interrupted or running sutures.

Wilkinson overcomes the defect by removing a triangular section of the skin on one side (usually the left) of the scrotum and closes the wound with sutures transversely to the length of the elongation of tissue.

One other operator whose name I have forgotten practiced the removal of an elliptical area of skin extending one-third of the ellipse anterior and two-thirds posterior to the middle of the lower border of the scrotum. This incision would include the skin only. The wound was closed by uniting the cut skin edges thus shortening the scrotum merely by the amount of skin removed. I could not possibly see any permanency of cure in this method as the skin surely would relax again.

But the operation which I am about to describe is, in my opinion, not open to the possible criticism to which the others are, and, although somewhat new, the results obtained have seemed to be lasting. The originator of this operation was Lt. Col. W. C. Borden and was performed many times by him, and, under his direction, by those of us on the staff of Walter Reed General Hospital, and always with most excellent results.

It consists in catching the redundant part of the scrotum with three or four hemostats in the line of the septum and, while these are extended and the testicles held as close to the external ring as possible, a long curved, rubber-protected clamp is placed from the base of the penis backward a short distance distally to the point of desired amputation. Then the skin only is incised on the proximal side of the clamp and dissected upward for about an inch. The two heavy curved clamps are then placed (one from above backward and the other from below forwards upon the raw surface). These include all the tissues of the scrotum, except the skin, as well as holding the septum. The redundant portion is now severed close to the under side of the rubber-protected clamp.

One chromicized cat-gut suture is started at the point of one of the two clamps last applied, and after fixing by tie, is "run" over and over to the base of the clamp. Another suture (interlocking the first) is begun at the point of the second clamp, and after tying is "run" over and over the second clamp. While removing the clamps the sutures are drawn tight and



fixed at either end. The skin wound is now closed with whatever method the surgeon prefers. Mostly a continuous suture was used but interrupted cat-gut or horsehair gave equally good results. I have found that it pays, sometimes, to suture all or part of the skin wound transversely to the line of incision. This, however, is a matter of judgment at that stage of the operation.

There are several advantages in this operation over any that it has been my pleasure to see done. All redundant tissue is removed. The mischievous dartos cannot back away and give all sorts of trouble. There is practically no bleeding. A much stronger scar is formed, and hence, there is much less possibility of recurrence. The patient comes through with a fourteen-year of age scrotum and is pleased. The anatomical relations of the tissues are as before operation. And the operation is simplicity itself.

There is only one caution that I can think of as a result of observation of many operations and that is to use a non-cutting needle in placing the skin sutures. Only one case in my experience had any complication, and this was caused by the use of a cutting needle in suturing the skin. A too deep "bite" cut one of the sutures in the deeper tissues and the patient has a severe hemorrhage which necessitated opening of the wound and a hunt for the bleeding vessel and a re-suturing of the skin after which he made a rapid recovery.

The operation can be done under local anesthesia but I prefer the general method as the time consumed is very short and the general anaesthetic is quicker and no more dangerous to the patient.

I trust that I have made this as clear to you as it is in my mind and that you will try this method on your next case rather than have him condemned to a "jock-strap" for the remainder of his life.

## EDITORIAL

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### COMING LEGISLATION.

IT was our pleasure to be an invited guest at the recent meeting of the Pennsylvania Medical Legislative Conference. Dr. Addinell Hewson, Jr., an eminent teacher of anatomy, was present, and directed attention to a bill passed at the meeting of the Legislature, a bill that provided that all bodies unclaimed by relatives or friends shall be placed at the disposal of undertakers, who shall give such bodies burial at an expense to the State, an allowance of fifty dollars per body being appropriated for the purpose. As a result of this legislative enactment, the supply of anatomical material for the medical colleges has decreased and at the present time, but about 60 per cent. of the bare necessities is available. Such a condition of affairs is deplorable. However unpleasant it may be to one's sensibilities to think that a human being is not accorded regular burial, we must realize that dissection and correct anatomical teaching must continue and that neglect of the same is an act of inhumanity to the living. Dissection is a matter of benefit to the public at large, and not to the physicians, excepting so far as a correct knowledge of anatomy increases the value of their services to their patients.

The bill passed at the last session was, so it is alleged, backed by a large coterie of undertakers whose representatives were at hand from the time of the opening of the session until the passage of the bill, looking after every point of vantage, losing no opportunities at any time. It was pushed largely, if not entirely, as a matter of pure business, which, in this instance, means financial gain for the time.

The disposal of the pauper dead has frequently been a matter of graft. Even in the days when the appropriation for the disposal of unclaimed bodies was but ten or fifteen dollars, the position of official undertaker for the county or district was much sought by a certain class. The outsider knowing well that while high cost of living is a problem of recent times, that of the high cost of dying is of much older date, he well ponders over the possibility of a funeral and burial at ten or fifteen dollars. In those days, there was a game

played. The undertaker is alleged to have taken charge of the body, and then by skilful diplomacy succeeded in interesting the friends of the deceased, so that in the end he received instructions to give the body a good burial.

There are undertakers and undertakers. Some, the majority, with a regular clientele, look upon their work as a profession, as one of honor, and scorn sinister methods in the securing and transaction of business. Others, always on the lookout for the dollar, stand ready to perform any little trick that will add to the personal exchequer. The public and, we fear, physicians also, fail to realize the necessity for honor and integrity upon the part of undertakers. No class of men has better opportunities for doing wrong with small risk of detection than have they. As a corollary, the majority of them take pride in the confidence reposed in them, and accordingly, the confidence is never abused. Of the remainder, we need say nothing. Black sheep exist in every phase of life, and it is the black sheep that make the trouble in the world.

The Conference, after listening to Dr. Hewson, passed a resolution which pledged its assistance to him in his efforts to secure a legislative enactment that shall supply the medical colleges of the State with sufficient anatomical material.

Following upon Dr. Hewson's address, it was announced that the anti-vivisectionists will be very active the coming winter. It was stated that at the last session, the anti-vivisection interests paid out \$20,000 for attorneys' fees alone to secure the passage of their favored bill. We know that that bill failed, and that it *will be presented again*. This matter is one of interest to humanity in every State of the Union. Physicians and humanitarians should take a strong stand to secure the defeat of it and all kindred measures. Without vivisection, medical science must come to a standstill. The activities of the anti-vivisectionists are greatly in evidence at the present time. Their societies are well organized. Their treasuries are replete with the sinews of war. The individual members are interviewing legislative candidates systematically and securing pledges for support, and medical science has, as a result, a fight for its existence. Virtually the question is narrowed down to two questions which may be formulated as follows: "Who shall suffer, humanity or the lower animals?" Or, if you please, "Shall the sufferings of humanity be mitigated at the expense of the lower animals?"



A third matter in prospect this winter is the Osteopathic Bill. Like that of the anti-vivisectionists, this has good financial backing. It is alleged that but a few weeks ago, 35 prominent osteopathic physicians at a conference subscribed \$100.00 each to aid its passage. Briefly, this bill is identical with the Geary bill defeated two years ago. Its object is to give osteopathic practitioners all the rights of medical practitioners, and virtually nullifies the present medical practice act. We commented on it over a year ago, and condemned the proposition as a "kitchen entrance" to the medical profession, and advised that if the osteopaths wished full medical honors, they should immediately place their college in the list of Class A medical teaching institutions, and require the preliminary medical educations: that of a high school course plus two collegiate years, and the hospital year following graduation. We doubt very much if any one will oppose their laudable ambition to become full fledged practitioners of medicine if they agree to the same standards as those required of the regular schools of medicine.

Other bills are in prospect in Pennsylvania and elsewhere. Some of them of the most absurd character. We have said nothing concerning the all-important question of compulsory health insurance. At present it looks very much as though the bill is doomed to an ignominious end—but one can never say.

As to medical legislative matters there is one thing very evident and that is the physicians generally require a very hard jolt to start them to activity concerning measures which affect them vitally. To use common parlance, they "*sleep at the switch*," until positive danger rouses them from their slumbers. In the meantime, the enemies of the profession are active, and succeed in putting through their many iniquitous measures. Legislators know nothing whatever concerning the actual value of medical questions, and so long as doctors offer no objections are acquiescent in the passage of a bill which on the face of it presents advantages to the public, and accordingly pledge their support to it.

There are times for objecting to a bill, and these are always early. In very important matters it is a good plan to obtain the attention of candidates during the canvass for the primary elections. Especially is this true in communities where nominations are won by scant majorities. Another time is at the general election, though not much relief is to be expected in localities where the nomination is equivalent to an election.

Lastly comes the activity at the State Capitol when the bill is presented for serious consideration. It is too common a practice to let a bill go to second and even to third reading before offering objections. This is not good business. The thing to do is to scotch a bad measure while it is still young, and before it has obtained a large following.

As soon as the results of the coming elections are assured it is the duty of every physician to become acquainted with all medical bills to be presented at the coming meetings of the Legislature. He should thereupon interview the representative or senator of his district and give him the proper educational training that will enable him to vote correctly for the benefit of his constituents.

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### ACIDOSIS.

THE term "acidosis," being a catchy phrase, has unfortunately become a popular diagnosis and now occupies the place in medicine which such phrases as "uric acid diathesis" and "autointoxication" formerly held. Not that we wish to cast any reflections upon the validity of using the term acidosis in its proper place; however, many conditions have been attributed to an acidosis without the slightest proof that such a condition was present. On the other hand, cases with a serious reduction in the blood bicarbonates, either due to renal insufficiency or to the accumulation of acetone bodies in the blood, have been overlooked because the proper tests for determining this condition were not made.

An important fact to bear in mind in conjunction with acidosis, is that there are no reliable clinical signs upon which this condition can be recognized until it has developed to a dangerous point. We must, therefore, be thoroughly conversant with the laboratory methods which are both practical and valuable in the early recognition of an increase of acid radicals in the blood plasma.

One of the simplest tests is that devised by Palmer and Henderson. This test is based upon the fact that when the normal buffer substances in the blood plasma, namely, the bicarbonates and phosphates are more or less exhausted by the accumulation of non-volatile acid substances in the blood, the individual's alkaline tolerance rises. In a normal individual

four to five grams of bicarbonate of soda causes the reaction of the urine to become alkaline while in acidosis much larger quantities are required.

Acidosis occurs when non-volatile acids, the result of a perverted metabolism, accumulate in the blood beyond the point at which they can be promptly eliminated or neutralized by the buffer substances in the blood plasma, namely the bicarbonates and phosphates. The commonest acids encountered in acidosis are the acetone bodies. These are derived from the fatty acids of the foods or in some cases from the body fats themselves, being intermediary products of incomplete combustion. Normally fats are oxidized into carbon dioxide and water; under certain abnormal conditions of carbohydrate metabolism, or in certain toxic states, the acetone bodies accumulate in the blood. The same thing may happen in carbohydrate starvation for it has been determined that "the fats are burned in the flame of carbohydrate combustion." This explains why acidosis frequently develops in a diabetic when he has been too abruptly deprived of carbohydrates.

In the early stages of such an acidosis, acetone alone appears in the urine, since this substance is nearer to complete oxidation than the other acetone bodies and is, therefore, the first evidence of a failing combustion of the fats. Acetonuria is frequently detected in febrile disturbances and digestive derangements and is not necessarily a serious condition. If the inability to oxidize fats, however, becomes still more pronounced then the more dangerous acetone bodies, namely acetoacetic acid and oxybutyric acid make their appearance and a serious increase of acid radicals with a corresponding decrease of carbon dioxide in the blood plasma occurs. When the H-ion concentration of the blood increases beyond a certain point there is a corresponding inability of the blood to take up carbon dioxide. Consequently, air hunger and increased respiration set in, without, however, a cyanosis, as usually exists with the dyspnoea of respiratory affections.

The important clinical methods for detecting acidosis are the determination of the acidity of the urine by titration, using phenolphthalin as an indicator; the estimation of urinary ammonia and the determination of the carbon dioxide tension of the alveolar air. None of these methods are too complicated for general use and they are of great practical value in the treatment of metabolic disturbances.

C. S. R.



## WHO'S AHEAD?

"Some Observations On Chronic Arthritis," is the title of an article by Draper, in the *American Journal of Medical Sciences*, September, 1920. In this up-to-the-minute article the author mentions rheumatic types and associates the occurrence of the disease with endocrine disturbances and their associated conditions; with asthma and eczema and cites bony changes. He also cites some of the modalities, if we may, of the disease. But the interesting feature of the paper is the therapeutic measure adopted which, the author says, was "By the old and homely method of the stings of honey bees." This paper should have been written by a homœopath, as it is the proving, augmented by modern methods, of Apis. "In one case a menstrual disturbance which had frequently amounted to complete amenorrhea for as long as eight months, completely cleared up," after being stung by bees. Turning to a popular pocket materia medica, we find under apis, "Menses suppressed." Some homœopathic indications for apis are, "Synovitis, knee swollen, shiny, sensitive, sore, with stinging pain." Draper writes, "In the first place the bee sting produces a lesion locally which is the perfect replica of an urticarial weal; later on there is generalized diffuse swelling, with redness and heat and pain and stinging sensation which resemble the lesion of acute rheumatic fever." In short, the article carries throughout a confirmation of the efficacy of apis, it appears in a modern setting and is published to inform physicians that there is something worth while in the sting of the honey bee as a cure in rheumatism. In the meantime many homœopaths continue to administer salicylates, coal-tar products, phylacogens and mixed vaccines in the treatment of rheumatism, both acute and chronic.

J. G. W.

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A DIALOGUE.

PATIENT.—Doctor, your bill calls for twenty-five dollars. The many expenses attendant upon my wife's illness, amounting to nearly three hundred dollars, have come pretty hard on me, and I have come to ask you if you will not take fifteen dollars in full payment, if you can afford to do so?

DOCTOR.—Yes; I can afford to do it, because I am so

busy that I need but few comforts in this world, but my wife and children need the money, and in justice to them, I do not see how I can give you the difference.

PATIENT.—Why, doctor, what do you mean by giving me the difference?

DOCTOR.—Simply this. Suppose you paid that bill in full, and then I turned around, and presented you with the ten dollars which you ask me to donate to you. In other words, I take from myself and family ten dollars to help you support your wife. How does that sound?

PATIENT.—Rather crude, I must say.

DOCTOR.—But brutally frank, is it not? It might almost be called insulting if I did such a thing; and yet I see no difference. You would ask nobody but a doctor to lessen his charges to you in order that you might meet other bills.

PATIENT.—But, Doctor——

DOCTOR.—Just let me put it another way. You live at quite a distance from me. You will admit that it cost me in the use of my automobile at least \$3.00 in direct expense, to say nothing of the fixed charges, wear and tear, depreciation, etc. I spent not less than five hours' time on your wife's illness. The taxicab drivers around the corner would have charged you for the same trips somewhere in the neighborhood of ten dollars. You ask me to take fifteen dollars in return for my services. Now please figure it out for yourself. You are really asking me to attend your sick wife for a less fee per hour than the taxicab driver receives, to say nothing of the fact that he generally receives an additional tip from his passenger. Really, I believe that I will find it better business to hack out my car at four or five dollars per hour, and not play the hypocrite in using my diploma for the sake of getting less money out of the car than does the chauffeur.

Patient pays his bill; leaves in an angry mood; thinks the doctor is lacking in humane instincts, and hunts up some other medico who will serve him hereafter.

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#### COMPULSORY HEALTH INSURANCE NUMBER.

OWING to the importance of the subject, the next number of the *HAHNEMANNIAN* will be devoted very largely to a discussion of the subject of Compulsory Health Insurance.

We have on hand the discussion held at the late meeting of the Homœopathic Medical Society of the State of Pennsylvania, and a couple of excellent papers. We feel that it is a good thing to present this subject *en masse* rather than to string it out with tiresome details over an indefinite period. Compulsory Health Insurance concerns the profession as a whole. The initial fight was in New York and was won by the medical profession. The supporters of the measures are making their next attack in Pennsylvania. The result is likely to be of more than ordinary importance, for if won by these supporters the Compulsory Insurance Bill is likely to come up once more in New York State—if lost by a substantial majority it is likely that this idealistic scheme will not be heard of again in State legislatures for many years. We judge from what we hear from Iowa and other Western States that the matter is being agitated elsewhere very strongly.

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#### AN UNSOLICITED TESTIMONIAL.

QUITE recently the Bell Telephone Company solicited from the secretaries, the lists of the members of the three State Medical Societies of Pennsylvania. The object in securing these lists was to have on file a complete record of the ethical physicians of Pennsylvania.

It would seem that there can be no greater testimonial of the standing of our State Societies than the above statement. A large corporation with many millions of dollars invested wishes to learn who of the physicians are worth while, and it goes to our organization headquarters for the information.

Does the above not teach that every physician of good standing should join his county, State and national organization?



## GLEANINGS

### MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

GLUCOSE AS AN ADJUNCT MEASURE IN THE THERAPY OF PNEUMONIA.—John, of Cleveland, presents a strong plea for the use of glucose as an adjunct measure in the treatment of pneumonia. We have already referred to the subject in these columns, especially in the use of glucose to lessen intracranial tension and thereby relieving delirium. Also in the article on influenza by the abstracter, the use of 5 to 10% glucose solutions administered by the Murphy drip, was strongly advocated. Within the past year or so, glucose has come to the front very strongly as an intravenous remedy. The writers on the subject seem to have no fear of the remedy. There is, however, a very serious matter which may arise should there be any carelessness in the preparation or keeping of the glucose solution, for under favorable conditions it is possible for such to become very putrid in an incredibly short space of time. However this is not to be taken as an objection to what is otherwise a good treatment, rather it teaches us that the utmost care must be observed in preparing and keeping the remedy. So much for personal remarks, and now for John's conclusions:

"1. That the administration of glucose is without danger provided any reasonable care is used. In the 1200 administrations not a single accident developed.

2. That the patient is made comfortable and sleep is provided for him. Through this the whole organism is strengthened for the prolonged fight against the infection.

3. That the temperature is lowered.

4. That nutrition is provided for the overtaxed heart muscle without having to go through the ordinary digestive processes, storage in the liver as glycogen and reconversion into glucose again before it can be burned by the tissues. 100 to 300 calories is thus supplied to the body per each dose.

5. That a considerable amount of fluid is provided for the circulation. This together with the preceding slows the heart, producing thus artificial rest.

6. That the elimination through the kidneys and the skin is increased.

7. That practically all the medication can be supplied in the glucose; thus a much more accurate dosage can be depended on.

8. That the antipneumococcic serum type I or the antistreptococcic serum, the antitetanic serum, can be administered in this glucose medium. This is far superior to saline, for glucose will do much more than saline, thus being a much more rational medium to use as a diluent for any intravenous medication.

9. That the use of glucose is strictly a physiological measure and is to be used as such."—*The American Journal of the Medical Sciences*, October, 1920.

VIRULENT DIPHTHERIA BACILLI CARRIED BY CATS.—We often hear of the acute infections being carried to humans by the lower animals. A very large portion of the information concerning this subject is supposititious,

rather than otherwise. Positive scientific proof of such transmission is afforded in a case reported by Major Simmons of the Medical Corps, U. S. A. His article proves the following facts:

1. An elderly lady developed a fatal diphtheritic pharyngitis after close contact with a cat (A) which had been sick one week.

2. A second cat (B) which had been in contact with the first cat (A) became sick and died ten days later.

3. The patient had a grayish-brown pseudomembrane covering her uvula, tonsils and posterior pharynx. Cat A had a small yellowish-gray pseudomembranous ulceration in the left nasal passage and Cat B showed ulcerations of both vocal cords, covered with a grayish-white false membrane.

4. Diphtheria bacilli of intermediate virulence for guinea-pigs were isolated from all three lesions.—*Amer. Jour. of Med. Sciences*, October, 1920.

INVOLVEMENT OF THE AURICLE AND CONDUCTION PATHWAYS OF THE HEART FOLLOWING INFLUENZA.—Hamburger reports six cases of myocardial involvement, the parts affected being the auricle and conduction pathways of the heart. The literature hitherto presented together with Hamburger's observations justifies the following grouping of post influenzal complications:

- (a) Fatal cases showing acute parenchymatous degeneration and vacuolization of the myocardium.

- (b) Non-fatal, acute cases, showing involvement of auricle and conduction system during height of infection, with complete restoration to normal cardiac mechanism with subsidence of infection. Duration two to six weeks.

- (c) Non-fatal chronic cases with arrhythmia and involvement of the auricle persisting and causing partial invalidism long after subsidence of acute infection. Duration twelve to seventeen months—plus.

Suggestion is offered that acute respiratory infections (Influenza, Streptococcus) single out early the auricle and conduction pathways of the heart."—*American Journal of the Medical Sciences*, October, 1920.

THE INFLUENCE OF SMALLPOX AND VACCINATION ON PULMONARY TUBERCULOSIS.—There is a popular idea that smallpox and vaccination on the one hand, and tuberculosis on the other, involve important modifications in the clinical course of each and there are many who believe that vaccination of the tuberculous subject is a dangerous matter. Who originated this conception it is hard to say. Literature does not give us positive data as to actual facts. The idea is rather traditional than scientific. Howk and Lawson have been afforded the opportunity of making real observations covering the question. In the autumn of 1914, an epidemic of smallpox broke out at the Tuberculosis Sanatorium of the Metropolitan Life Insurance Company. At the time there were 178 tuberculous inmates in various stages of the disease. All were vaccinated. There were seven cases of smallpox. An official report of the experiences has been delayed in order to give ample time to determine the end results of Howk and Lawson's experience. After six years then, they present the following conclusions:

- "1. Smallpox, occurring in patients with pulmonary tuberculosis, runs a course not noticeably different from that encountered in well people. The symptomatology, appearances of exanthem, and duration of the smallpox, are not influenced by the presence of tuberculosis.

2. In early, inactive cases of tuberculosis with favorable prognosis there is no apparent interruption of recovery when complicated by smallpox.

3. In one active advanced case there was a disappearance of sputum and bacilli after smallpox, lasting for four months.

4. In one very active advanced case there was a permanent disappearance of sputum and bacilli immediately after the smallpox. The disease was progressive up to the time of smallpox and retrogressive thereafter.

5. The seven recovered from smallpox and six are alive and well at present.

6. The presence of tuberculosis does not affect the normal course of vaccinia. Tuberculosis in any stage or any degree of activity was not affected by vaccination, either favorably or unfavorably."—*The American Review of Tuberculosis*, Sept., 1920.

ULCERATIVE STOMATITIS CAUSED BY ANTIPYRIN AND ASPIRIN.—Dr. Hubert Bristowe reports a personal observation on himself. On several occasions he took ten grain doses of antipyrin to relieve hemicrania, whereupon he was seized with attacks of stomatitis, sometimes simple and sometimes ulcerative. On two occasions he had concurrently anal ulcers. He since discovered that this disease always followed upon his taking antipyrin.

Bristowe also reports the case of a young lady suffering from an aggravation of old sphenoidal sinus disease. She was also liable to attacks of acute ulcerative stomatitis which further observation demonstrated always followed the administration of acetosalicylic acid. These ulcers resisted local treatment. Discontinuance of the drug led to a rapid and complete cure.—*British Medical Journal*, September 11th, 1920.

DIURNAL VARIATIONS IN THE HAEMOGLOBIN CONTENT OF THE BLOOD.—Criticism has often been made concerning the uncertainty and unreliability of haemoglobin estimates, much of said criticism being directed against either the technique of the observer or the instrument employed. That all of this criticism is not just is shown by the investigations of Dreyer, Bazet and Pierce. Much of the discrepancy is apparently due to diurnal variations as shown by the following summary of their observations:

"1. The diurnal variations in haemoglobin percentage met with in man and animals are very considerable and may even reach as much as 30 per cent., while 10 per cent. changes are of more or less common occurrence. On an average the excursions seem to be more marked in individuals or animals with a low haemoglobin content of the blood.

2. In attempting to establish the normal haemoglobin content in a series of individuals it is essential to take the observations at a time of the day when the daily variations are found to be the smallest—i. e., late afternoon between 5 and 7 P. M.

3. In the study of any phenomena where alterations in the concentration of blood are concerned it is necessary to view them in the light of the marked normal diurnal variations that may occur."—*The Lancet*, September 18th, 1920.

#### PATHOLOGY

Conducted by JOHN G. WÜRTZ, M. D.

THE BLOOD-SUGAR TOLERANCE TEST AS AN AID IN THE DIAGNOSIS OF GASTRO-INTESTINAL CANCER.—Friedenwald and Grove (*Amer. Jour. Med.*



Sc., September 1920, p. 313) give a concise review of the observations of various workers regarding sugar tolerance. Their own work leads to the charting of a series of curves demonstrating sugar tolerance. 100 grams of glucose are ingested after an all night fast, then specimens of blood are taken and in cancer of the intestinal tract there is delayed elimination or increased tolerance. The sugar percentage remains the same after two hours as it was at the end of forty-five minutes. The authors remind us that this test is only an aid in diagnosis of these conditions and is not specific, since atypic and intermediate curves are sometimes encountered. After the citation of three cases, they conclude that the curve of sugar tolerance found in carcinoma of the gastro-intestinal tract is rather characteristic of the disease and differs from the curve of tolerance found in cancer of other parts.

THE BLOOD PICTURE BEFORE AND AFTER GOETSCH EPINEPHRIN TEST.—Trott (*Arch. Inter. Med.*, September 1920, p. 352) began her work with the intention of learning whether or not the injection of epinephrin augmented the leukocyte picture in hyperthyroidism as it does other symptoms. The results of her studies were affirmative. She found that slight toxic goiter cases with nearly normal blood picture presented the picture of an advanced case after the administration of epinephrin, and that the change took place in less than an hour.

A CASE OF MASSIVE LIPOMA OF THE MEDIASTINUM.—R. S. Leopold (*Arch. Inter. Med.*, September 1920, p. 274) reports a case of pure lipoma in the anterior mediastinum. The tumor weighed 17 pounds and 6 ounces. In his review of literature, Leopold recalls the scarcity of reports and presumably the scarcity of occurrence of lipoma in the mediastinum. Only four cases he found reported. In his own and the other cases, the symptoms found were mostly those of pressure. All of the patients died.

ENDOTHELIAL LEUKOCYTES IN THE URINE SUGGESTING TYPHOID INFECTION.—Pepper (*Amer. Jour. Med. Sc.*, September 1920, p. 336) tells of a case of urinary typhoid infection in which the diagnosis was arrived at by the finding of endothelial leukocytes in the urine. The endothelial leukocytes are the active cells in the reaction against typhoid infection and their presence in the urine, without that of other leukocytes, suggested a Widal and urine culture which proved positive to typhoid. Endothelial leukocytes are not difficult to distinguish from other leukocytes, so the search for them may be a means of detecting typhoid carriers.

THE EFFECT OF ETHER ANESTHESIA ON THE ALKALI RESERVE.—Carter (*Arch. Inter. Med.*, September 1920, p. 319) reports the results of experimental studies which lead him to conclude that ordinary ether anesthesia causes a decrease in the carbon dioxide combining power of the blood and that it is after the first hour of anesthesia that the greatest diminution occurs. As the experiments were conducted upon normal dogs, dangerous low levels were not encountered, probably because it is difficult to produce an acidosis in dogs. However, what the results of too prolonged anesthesia upon a person whose metabolism was altered before operation cannot be determined; but the studies carried on by Carter suggest that they may prove serious.

## DERMATOLOGY

Conducted by RALPH BERNSTEIN, M. D.

ACQUIRED CIRCUMSCRIBED HYPERHIDROSIS.—Pusey describes the case of a girl, twenty-two years old, who had a sweating area on the extensor surface of the wrist and on the back of the hand toward the ulnar side, from  $2\frac{1}{2}$  to 3 inches wide and 5 inches long. It was sharply defined and its location did not vary. The skin was slightly pinkish and sodden. Sensation in it was diminished, but it was otherwise normal. The sweating occurred in almost constantly repeated attacks. By applying a 25 per cent. solution of aluminum chloride cautiously over the affected area, the sweating was checked in the course of a week or ten days, and there has been no unusual recurrence for two months.—*Journ. Amer. Med. Assn.*

ECZEMA IN INFANTS.—As the skin of children suffering with eczema is so sensitive, Dr. Oyarzabal states it may be advisable not to wash the eczematous regions with soap and water, but to use olive oil, cold cream, or a hot 3 per cent. solution of boric acid. The affected regions in children should also be covered with a bandage to prevent scratching. If the condition exists on the face, and it is intensely itching, he advocates small doses of bromide or chloral to insure the child's sleeping. When the scalp is involved, he says the conditions rapidly improve under a 2 per cent. salicylated yellow petrolatum or oil containing 1 to 5 per cent. anthrasol, cleansing once a day with olive oil and occasionally washing with an infusion of chamomile. He also states that eczema may also yield to roentgen-ray exposures.—*Jour. Amer. Med. Assn.*

LEPROSY IN PERNAMBUCO.—Rocha states that the asylum for lepers founded in his district in 1786, and still efficiently functioning, has aided materially in keeping the number of cases at a low figure. There are now forty-seven men and thirty-six women inmates. Segregation is not compulsory.—*Journ. Amer. Med. Assn.*

POTASSIUM PERMANGANATE IN TREATMENT OF SMALLPOX.—Bender condemns red light therapy and endorses the potassium permanganate treatment of smallpox as effective in dealing with the dermatologic aspects of the disease. The convalescent stage is much shortened on account of the accelerated desquamation process, especially if the peeling of the hands and the soles of the feet is aided by mechanical removal. The isolation period is reduced, which lessens the number of melancholy states and hysterical attacks. Dreyer has the hands, arms and face painted with a saturated aqueous solution of potassium permanganate three or four times a day for the first two days, and then the entire body once a day. This stains the skin brown and thus realizes a kind of colored light therapy, he says, besides its other advantages. Bender found it impossible to apply the solution so often or in such concentration, as it caused smarting, but by diluting it and applying it to parts of the body at a time, he obtained excellent results in his eight cases.—*Journ. Amer. Med. Assn.*

TREATMENT OF PITYRIASIS ROSEA AND TRICHOPHYTOSIS.—Fried recommends mercurial ointment for the treatment of pityriasis rosea and trichophytosis, as he claims it affects a speedy cure and has the advantage of being much cheaper and simpler than the roentgen ray.—*Journ. Amer. Med. Assn.*

ETIOLOGY OF ECZEMA.—Hazen suggests the following as clinical entities now well established: Dermatitis due to external irritation; vagotonic dermatitis; urticarial dermatitis and dermatitis due to disturbed food assimilation (the eczema of young children). He claims that none of these conditions should be classed as eczema, as this only results in confusion and a failure to discover the cause.—*Journ. Amer. Med. Assn.*

TREATMENT OF HYPERTRICHOSIS.—The roentgen ray, radium or carbon dioxide do not appeal to Young as the best method for the removal of superfluous hair. He prefers electrolysis which produces excellent cosmetic results without discernible scars.—*Journ. Amer. Med. Assn.*

METABOLISM IN THE SKIN.—An investigation of the chemical composition of different parts of the body in the new born has been conducted by Klose, who reports the results of his research on skin of the back of nineteen infants. The skin seems to be the first part of the body called on to store water in pathologic conditions, and it is also active in the mineral metabolism, storing and eliminating mineral substances independently of the water metabolism.—*Journ. Amer. Med. Assn.*

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## PEDIATRICS

Conducted by C. SIGMUND RAUE, M.D.

MILD CHRONIC NEPHRITIS IN CHILDREN.—Dr. Lewis Webb Hill describes a mild form of nephritis which is seldom seen in adults. The etiology of the condition is usually some infection, particularly tonsillitis. The most frequent symptoms are: Lack of appetite, loss of energy, failure to gain in weight, and slight anemia. Physical examination reveals nothing essentially abnormal. The urine contains a small amount of albumin, a few casts and perhaps a few red blood cells. The blood pressure is normal or slightly subnormal and there is no hypertrophy of the heart. Orthostatic (postural) albuminuria must be ruled out. There may be occasional acute exacerbations, where the urine will contain considerable blood, brought about by any acute infection or sometimes without apparent cause. These exacerbations are likely to be accompanied by slight or moderate edema. The renal function tests are of especial value in these mild cases. The phenolsulphonephthalein test is usually not much diminished in mild chronic nephritis, except during the acute exacerbations. A phenolsulphthalein excretion below 55 or 60 per cent., however, means in children that the kidney is severely damaged, but, on the other hand, a high excretion does not necessarily mean that the kidney is normal. The "two hour" renal test is a valuable one and the author uses it as follows: The child is put on a full normal diet containing a considerable amount of protein, especially with the noon meal. A capsule containing 1 gm. of salt, and a 2 grain pill of caffeine sodium benzoate is given with each meal. Here we have a diet containing a considerable amount of salt, protein and diuretic material, all of which will stimulate the kidney to its maximum efforts. Exactly 10 ounces of fluid is given with each meal, and no fluid or food whatever between meals. The urine is collected in two hour periods from 7 A. M. to 7 P. M., and the night urine from 7 P. M. to 7 A. M. Then all that is required is to record the specific gravity of each sample of urine. The



normal response shows a wide variation in gravity between the different specimens: In normal children there is always a variation of at least eight points between the lowest and the highest. The night urine in normal children is small in amount, and almost always has a specific gravity of 1.020 or over. The child with damaged kidneys, on the other hand, is unable to vary the concentration of the urine in this way, and the gravity of the individual specimens may vary only one or two points. The fixation may be at a high or at a low level, and may be high or low in the same patient at different times. It is apparently the fixation of gravity which is important, and not the level at which it is fixed. Children with mild chronic nephritis often show a fixation when the phenolsulphthalein test is normal. A fixation does not necessarily mean a severely damaged kidney, but it is undoubtedly fair to say that if fixation exists, the kidney function is abnormal. General hygiene is the most important part of the treatment. The strenuous life must be strictly forbidden; this means plenty of rest, both physical and mental. The tonsils should be removed and the teeth should receive careful attention. It is of the utmost importance to guard the child against all sorts of acute infections, such as colds, bronchitis, or measles. The diet may be thus summed up: Meat, fish, or eggs once a day; no meat soups; a moderate salt intake, and plenty of water, otherwise the diet can be the same as for any other child. There are three prognostic possibilities to be considered in mild chronic nephritis. First, the kidneys may recover entirely, after a period of several years' albuminuria. Secondly, a severe and fatal chronic nephritis with large amounts of albumin in the urine, and edema, may supervene; and thirdly, contracted kidney may develop, giving rise to the clinical picture known as chronic interstitial nephritis.—*The Journal of American Medical Association*, August 28, 1920.

ENURESIS.—Pisek (*Med. Clin. N. America*, Sept., 1919) believes that the great majority of cases of enuresis are due to a lack of control of the sphincter centers or the higher cerebral centers. If voluntary control is obtained over the lower center, the patient is cured. Atropin may help a little, probably by decreasing the desire to urinate. Enuresis is more common in active, energetic children, who by night time give evidence of neuromuscular fatigue. The cure of these cases depends on detailed management, which includes rest, diet, bladder control exercises, psychic impressions and, in certain intractable cases, mechanical irritation of the sphincter. Having removed possible physical causes, such as phimosis or adenoids, the physician must acquaint himself with the details of the child's life, so that fatigue and excessive nerve stimulation may be avoided. Meats, meat soups, tea, coffee, pastry and all highly seasoned foods should be avoided. A two day rest cure is often beneficial, requiring that the child have his breakfast in bed, and he is not allowed out of bed until lunch time. Such a plan, followed for two days each week, at the beginning and the end of the week often helps a great deal. The child should have a dry supper with as little liquid as possible after 4 P. M., and there should be no strenuous play in the afternoon. He is put to bed one hour after supper and is taken up to urinate when the parents retire. During the day the child is required to urinate and to stop at the word of command. This teaches

the high centers to control the act. These control exercises are done at least three times a day in the presence of an attendant. The patient is given a report card which is filled out every morning indicating whether the bed was wet or dry and the number of times the control exercises were done. Young children who have not learned to write may affix a gold star for a dry bed and a red star for a wet one. These reports, which are mailed to the physician, make a deep impression and are extremely valuable in the cure.—*Amer. Jour. of Diseases of Children*, September, 1920.

THE EFFORT SYNDROME IN CHILDREN.—C. G. Kerley, M.D., calls attention to the fact that there exists a special class of constitutionally inferior, substandard (MacFarlane) children. Thus constituted, they enter the world and thus they continue throughout perhaps a long life regardless of attempts at improvement. A trait common to all is inability for sustained effort. Physicians and educators and all interested in the development of the young, should appreciate, that what often passes for indifference, indolence, and inattention may be of constitutional origin and impossible of correction. Where such is found to be the case, the child's curriculum should be made to fit the child and not the child fit any cut and dried curriculum. All such attempts mean energy wasted.—*Archives of Pediatrics*, August, 1920.

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## OPHTHALMOLOGY

Conducted by WM. M. HILLEGAS, M.D.

CYCLODIALYSIS.—Gradle quotes Heine: "The more acute the glaucoma the more urgent the indications for immediate operation, the better will be the results of iridectomy; the more chronic the glaucoma and the less urgent the indications for immediate operation the more favorable will be the results of cyclodialysis." In these brief sentences Heine gives the indications for and the contraindications for this operation.

Gradle's conclusions are: (1) Cyclodialysis is an operation that decreases increased intraocular tension by freeing the angle of the anterior chamber of adhesions; (2) the particular indications for the use of cyclodialysis lie in the essential chronicity and freedom from inflammatory reaction of the disease; (3) cyclodialysis is distinctly contraindicated in acute glaucoma, in glaucoma of an exudative or inflammatory type, and in cases where an immediate operation is desirable; (4) the effects of a cyclodialysis must be judged by the behavior of the central vision, the visual fields and the intraocular tension; (5) in about 50 per cent. of the cases with proper indications cyclodialysis is successful; in about 20 per cent. of such cases it produces temporary results that usually become permanent by a second or even a third operation; in about 30 per cent. it is a failure.—*Amer. Jour. of Ophthal.*, Vol. 3, pp. 44—48.

ANGIOSCLEROSIS.—Angiosclerosis of the vessels of the eye in its relation to general diseases is well shown by Uribe Troncoso. The magnification produced by the ophthalmoscope permits excellent study of the retinal vessels. Changes found in the retinal vessels allow some conclusion as to the condition of the vessels of the brain, since both organs are supplied by the same trunk. The relation of affected retinal vessels to general diseases, pre-

mature arteriosclerosis, heart and kidney lesions is well known. The first stage of the sclerosis is rarely observed, because it gives no subjective symptoms. At this time the vessels are dilated from degeneration of the muscle and elastic fibers, from formation of spaces in the elastica and non-inflammatory swelling of the intima. The arteries are dilated and tortuous and they pulsate; the veins hardly share in the affection, but are at times alone affected.

Later thinning and distention of the vessel wall are replaced by thickening of the wall and contraction of the lumen by obliterating endarteritis and true sclerosis; the reflex becomes broader, the arteries appear like silver wires and show alternating contractions and dilatations; the veins are indented by the crossing arteries and varicosities are produced in them; the capillaries are tortuous and more numerous; the thickened vessel walls show as white lines and the brittleness of the vessels leads to hemorrhages; optic neuritis and white exudates may follow.

Retinal arteriosclerosis is a precursor or co-symptom of general sclerosis; thrombosis of the retinal artery is often a premonitory symptom of apoplexy; thrombosis of the vein is less serious. Retinal angiosclerosis is generally associated with kidney lesions, but is not always a sign of kidney affection. The retinal changes are degenerative and not inflammatory. Sclerosis of the choroidal vessels is of different diagnostic and prognostic value, and is mostly the result of syphilis, though found also in diabetes and nephritis. —*Ophthalm. Liter.*, June, 1920.

**PHOTOPHOBIA.**—Santos Fernandez has an article on extreme photophobia. His first patient had his cornea burned by cigar ashes, and treatment with lead water was followed by incrustation of the cornea that had to be removed to relieve the photophobia. Photophobia will make patients seek the darkness, and this will result in damage to the general health. Bandage in these cases is therefore indicated. Photophobia is found under different conditions such as foreign bodies, corneal abrasions and ulcers, iritis, phlyctenular disease, etc. Superficial abrasion of the cornea by a comb in one of his patients gave rise to the most violent suffering, while another patient whose cornea had been cut through was quite free of pain. After the eclipse of the sun in 1878 he saw cases of hyperaesthesia of the retina. In hysteria and incipient cataract patients will suffer from the glare. The central scotoma of alcohol or tobacco poisoning will make the afflicted shun the light. The blind can have no photophobia. Some patients see only with the rods, and seek therefore the dark. The pain in the photophobia of inflammations of the anterior part of the eye is due to continuation of the process to the retina. —*Ophthalm. Literature*, June, 1920.

## UROLOGY

Conducted by LEON T. ASHCRAFT, M.D.

**RENAL CALCULUS.**—Hutchinson (*Can. Med. Ass'n Jour.*, 1920 X, 250), after having briefly outlined the pathology, symptoms, physical signs, diagnosis and treatment of this condition, the author describes his own technique in performing the operation for removal of the stone, which is the treatment that he considers indicated in all cases of this condition, whether there are any symptoms present, in addition to a dull pain in the loin, or not. He lays stress on the fact that an early and careful urological examination should be made in every case in which a patient suffers with pain in the back, so



that an early diagnosis may be reached. Double ureteral catheterization should be performed before operation. He advocates the use of small transverse incisions, rather than a longitudinal incision.

CLINICAL CONSIDERATIONS OF TUMORS OF THE KIDNEY, WITH A REPORT OF TWO CASES OF MYXOMA.—Molla (*Med. Ibera*, 1920, C., 113-134) says that renal myxoma may develop without any symptoms, such as local or referred pain, hematuria and pyuria. In neither of the two cases reported was the diagnosis made until after operation, the preoperative diagnosis having been hydatid cyst in one case, and inflammatory retroperitoneal cold abscess of the vertebrae or appendix. Myxoma of the kidney frequently grows very large, but not so rapidly as a sarcoma in a child; nor does it produce the urinary symptoms and clinical manifestations of the latter. This is partly explained by the fact that commonly mechanical obstruction alone is produced by the myxoma, without invasion of the ureter. Invasion by contiguity occurs only in the late stages. The myxoma, therefore, differs from the sarcoma both clinically and anatomically, as the latter becomes generalized quite early.

RECENT ADVANCES IN THE DIAGNOSIS OF SURGICAL LESIONS OF THE KIDNEY.—W. F. Braasch (*Minn. Med.*, 1930, III, 2) states that the pyelographic data distinguishing lesions inside from those outside the kidney are the distance between the shadow and the pelvis, the relation of the shadow to the pelvis, and the existence of pathologic changes in the outline of the pelvis. He considers the substitution of sodium bromide as an opaque medium in place of the salts of colloidal silver and sodium iodide as a distinct improvement in the technique. Fluoroscopic examination of the kidney on the operating table will reveal any fragments of stone left after a lithotomy. Braasch divides renal function tests into excretion tests and retention tests. He explains how errors may be made in performing the phenolsulphonephthalein test. He divides these into two groups, errors of technique and errors of interpretation. The indigo carmine and the methylene blue, he also considers valuable tests of excretion. These tests can be made at the same time as the phenolsulphonephthalein test. Any case with less than thirty per cent. of function should be studied carefully before resort is had to operation, bearing in mind that this degree of retention may be due to some error in technique or interpretation, rather than to the condition of the patient. The combined phenolsulphonephthalein test may be normal, even in the presence of bilateral tuberculosis, bilateral lithiasis of the kidney and polycystic kidney. A test should be made of the excretion of each kidney separately. Retention tests have been advanced by the estimation of the uric acid, urea and creatinin in the blood. Forty milligrams of urea nitrogen for every 100 c. cm. of blood should cause a guarded prognosis to be made. A symptomless unilateral hematuria has recently come to be considered as due to a chronic infection of the renal papillae. Finally, the author refers to the use of the wax-tipped catheter for the purpose of detecting urinary stone.

SARCOMA OF THE PROSTATE.—Herrick, of Cleveland (*Annals of Surg.*, Feb., 1920) reports the case of a man of thirty-three who, several months before coming under the author's observation, had noticed that he had difficulty in emptying his bladder. By the end of two weeks, the trouble had increased to such an extent that he had to use the catheter. For seven months after this, he catheterized himself. He was entirely free from pain,

but lost twenty pounds during this time. Herrick found a large, smooth, elastic tumor, of uniform consistency, and not tender. A suprapubic operation was performed, and the internal meatus was found surrounded by edematous papillomata. Under this mass, the principal tumor was felt. The enucleation of this entire mass left a large cavity, which was obliterated by means of purse-string sutures. Three months and a half after this, a recurrence was found to have taken place in the prostatic region. Radium treatment was not successful, and the patient died, a little less than six months after the operation. A large tumor, completely filling the pelvis, was found at autopsy, as well as metastases in the liver and suppurative pyelonephritis.

The author states that he was able to find sixty-two cases on record, one-third having occurred before the tenth year, three-fourths before the fortieth year, and four-fifths before the fiftieth year. The most frequent symptom was obstruction of the bladder, and many cases showed obstruction of the lower bowel. Pain was not a prominent symptom in the younger patients. The differential diagnosis is from tuberculosis, syphilis and cancer. The therapeutic test should be resorted to if there are any facts in the history leading to a suspicion of the existence of congenital or acquired lues. Tuberculosis does not cause the prostate to enlarge so much as does sarcoma, and the prostate in that condition is of different consistency in different parts. Carcinoma usually occurs at a more advanced age than sarcoma does. The tumor is smaller, harder, of irregular outline, and often nodular. The time at which it occurs, its rapid growth, its uniform elastic consistency and the early obstruction to urination that it produces are the distinguishing characteristics of a sarcoma. The treatment is thorough removal of the tumor and the subsequent application of radium. The prognosis is most grave. Herrick found only one case in which death did not take place from recurrence. In that case, twenty-one applications of radium had caused the growth to disappear, but the authors who reported the case did not consider it cured.

URINARY TRACT PURPURA: A PROBABLE ENTITY.—A. R. Stevens and J. P. Peters (*Jour. of Urol.*, 1920, IV, 1) during a period of eighteen months in France, observed thirty-seven cases of this condition. In most of the cases, the onset was sudden, the condition being fully developed within forty-eight hours, although in some cases general symptoms preceded the development of those belonging to the urinary tract. The onset was marked by severe prostration, with malaise, headache, pain in the legs and back, gross hematuria, frequency and urgency of micturition, dysuria and pyrexia. During the febrile period, the disease was like an acute infection. The pains were of two kinds, those apparently due to general infection and those referable to the urinary tract. Herpes labialis was present in some cases. The initial temperature was commonly quite high, and the urine in the early stage always contained blood. Casts were found in the urine at some time in every case but one. In only one case was the patient when discharged from the hospital entirely free from symptoms and with constantly negative urinary findings. In most, there were still slight traces of albumin and casts in the urine when the men were sent to England. In all but four cases, the excretion of phenol-sulphonephthalein was diminished. The cystoscope, in every case, showed multiple small hemorrhages into the bladder mucosa, unassociated with ulceration, neoplasm or calculus. The hemorrhagic areas were found chiefly on the posterior and lateral walls of the bladder. There were no spots of hemorrhage near the ureteral orifices, and no blood could be seen issuing

from the bladder mucosa. If there was blood in the bladder when the cystoscope was introduced, blood could be seen coming from the ureteral orifices. Hemorrhagic spots could also be seen on the verumontanum. The author considers this disease as absolutely different from ordinary cases of acute nephritis, edema and dyspnea being almost entirely lacking. It differs from ordinary types of urinary infection in the comparative absence of pus cells in the urine, the absence of leukocytic infiltration about the bladder lesions and the consistently negative bacteriological findings. In many ways, this disease resembles, the authors think, trench fever. The bladder hemorrhages seem to be the same as those of any other purpuric lesion; but they think that a purpur of such frequent occurrence, limited in most cases to the urinary tract, is extraordinary enough to command attention.

GONORRHEA.—E. F. Muller (*Munch. med. Woch.*, Jan. 2, 1920) has employed provocative injections of a lactalbumin called solan, and gives a comparison of his results in a series of cases treated thus with those secured by injections of vaccines or blood serum. The purpose of injecting solan is to cause a great amount of irritation and thus increase the protective powers of the system. The injections are "intracutaneous," rather than subcutaneous. About six hours after the injection, there is some itching in the urethra, with an increase in the amount of excretion from the urethra, usually with a good many pus cells. If the gonococci have not become extinct, they will be found in this secretion. The test was successful, the author states, in cases in which the usual provocative methods had not succeeded. Some cases had lasted for one, or even two years, only a slight intermittent mucoid discharge having been present. The author considers this method preferable to the use of vaccine injections or of local irritating substances like nitrate of silver.

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## OTOLOGY, RHINOLOGY AND LARYNGOLOGY

Conducted by JOSEPH V. F. CLAY, M.D., F.A.C.S.

RADIUM IN THE TREATMENT OF MALIGNANT TUMORS OF THE NOSE AND THROAT.—Sonnenschein believes this method of treatment in malignancy of the nose and throat offers bright prospects but urges that details of preparation and its application be reported. It offers a great usefulness in relieving pain and hemorrhage and discharge in inoperable cases. Sarcomas are more responsive than carcinoma and the squamous type of epithelioma offers very little reaction to radium. Burns are common and even death may result from toxæmia. The diagnosis of nose and throat malignancy should be made by a competent laryngologist and the radium applied in co-operation with a radiologist.—*Jour. of the Amer. Med. Ass'n.*, September 25, 1920.

THE EFFECT OF TONSILLECTOMY ON THE RECURRENCE OF ACUTE RHEUMATIC FEVER AND CHOREA.—W. St. Lawrence has made extensive investigations in a series of cases in a children's cardiac clinic where unusual opportunity was afforded in the determination of pre-operative manifestations and the follow up system following operation, to determine the recurrences of lesions supposedly of tonsillar origin. Much attention was given upon admission to acute rheumatic fever, chorea, myositis, bone and joint pains (growing pains) and tonsillitis. The study included 94 children. Each had suffered from one or several of the foregoing groups of conditions. Fifty-



eight subjects were victims of organic heart disease. The ages varied from four to sixteen years. The period of observation ranged from six years to two years after operation. This feature of the study renders it of decided value. Sore throat recurred in 7% and in 22% two operations were necessary before removal of the tonsil was complete. Of acute rheumatic fever, one or more attacks had occurred previous to the operation. After tonsillectomy there was no recurrence in 35 cases or 84%. Of chorea forty cases presented attacks before removal of the tonsils. Following operation there were no recurrences in twenty cases or 50%. Sixty-one cases showed myositis bone and joint pains before operation. There were no recurrences in 47 cases or 77%. The cases of organic heart disease were 58 in number. Twelve of these had suffered at least one attack of cardiac failure before operation. Following operation one patient suffered one attack. He concludes his study with the remark that "tonsillectomy (complete removal of the tonsils) would seem to be the most important measure at present available for the prevention of acute rheumatic fever and the allied rheumatic manifestations."—*Jour. of the Amer. Med. Ass'n*, October 16, 1920.

THE IMPORTANCE OF PHYSICAL DEFECTS IN THE MENTAL DEVELOPMENT OF CHILDREN.—Dr. Jos. Pettee Cobb presents this subject for discussion before the American Institute of Homeopathy.

The attention of pediatricists and of social service workers has of late been powerfully interested in the study of nutrition both from the academic and from the practical standpoint. We recognize that this is a fundamental principle and rightly demands our special attention. Proper nutrition will prevent many defects; ideal nutrition for a number of generations would eliminate most defects; correct nutrition will cure many defects but we well know that it will not cure all defects.

Is there not still a tendency to expect that children will outgrow things? Are we not concerned more with the physical development than with mental development in the early years of life? Is it right to expect that nature will produce a well balanced mind in later years after an abnormal irritation has been constantly active during the first years of life, during that period when the differentiation of nervous function is developing under the repeated stimulation of peripheral impulses on nerve cells?

These are some of the questions to which the essayist thinks we can well afford to give careful consideration.

Physiologists tell you that the most rapid growth of the brain takes place during the first two years of life; that the important factors in this growth are nutrition, rest, peace and a freedom from irritations.

The brain that is impaired in its early growth is warped; will never be able to function normally in every direction; will develop its own idiosyncracies; will fail in some direction; cannot house a well balanced, normal mind.

A child's capacity for mental work bears a direct relation to his physical development. The work of any part of the brain will also bear a direct relation to the development of that particular part of the brain and of the normal development of the organs and tissues through which it is going to function.

Dr. Cobb emphasizes the importance of correcting such conditions as mouth breathing and refractive errors and removing all sources of reflex irritation.—*Journal of the Amer. Institute of Hom.*, October, 1920.

# THE HAHNEMANNIAN MONTHLY.

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DECEMBER, 1920

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## SPECIAL SESSION OF THE HOMŒOPATHIC MEDICAL SOCIETY OF PENNSYLVANIA FOR THE CONSIDERATION OF COMPULSORY HEALTH INSURANCE.

The President, Dr. Robert L. Piper, of Tyrone, opened the proceedings.

### *Ladies and Gentlemen:*

As YOU know, we have met tonight for a friendly conference on the State Health Insurance problem. I am pleased to inform you that we have the honor of having with us members of the Commission appointed by the Governor to study this question.

I am not going to express to you my opinions in regard to this subject. They were stated in my address this morning. I then told you that I believed a law of this character was opposed to all the principles of American independence and that it was unjust and humiliating to ask any American citizen to employ any physician not selected by his own free will and choice.

I will first call on Dr. Hillegas to explain what Health Insurance is.

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It gives me pleasure to introduce to you Dr. George A. Knowles, of Philadelphia, Chairman of the Medical Conference of Pennsylvania.

**PRELIMINARY REMARKS.**

BY

G. A. KNOWLES, M.D.,

CHAIRMAN OF THE STATE LEGISLATIVE CONFERENCE.

*Mr. Chairman, Ladies and Gentlemen:*

My duties as Chairman of the Medical Legislative Council of Pennsylvania are to take care of the legislative phase of the proposed Compulsory Health Insurance Law only. We all realize what a law of this kind would necessarily mean to the medical profession of this State. It would lower the standard of medicine and as we are now striving to train our students in the best possible way, this effort would go for naught.

If Compulsory Health Insurance becomes a law in Pennsylvania the doctor may be compelled to see as many as a hundred patients in his office in an evening, to care properly for whom we all know to be an utter impossibility. In my judgment such a law would be of no advantage to the people of this Commonwealth.

The members of the Commission present are open to argument and I am sure meetings such as this can not help but be of common advantage.

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**WHAT IS STATE HEALTH INSURANCE?**

BY

WILLIAM M. HILLEGAS, M.D., PHILADELPHIA.

*Mr. President, Members of the Commission, Members of Our State Society and Assembled Guests:*

THE one thing that I shall try to do this evening is to give you a clear understanding of just what State Health Insurance is. State Health Insurance, compulsory in character, is a solution proposed to remedy the inadequacy of present methods of relief for industrial employes for sickness and its consequent financial distress. The sickness problem of industrial employes is a real one, as it has been established by the investigations of the Pennsylvania Commission on Health Insurance, and also by similar commissions in other States



that the present facilities for the care of sick industrial employes are unsatisfactory, and that the individual working man fails to avail himself of the agencies at present in existence for his insurance against the dire results of illness. Even in these days of continued high wages, they do not do so. Only about 33 per cent. of wage earners carry any form of Health Insurance, and least of all among those who need it most. Does any law so far proposed anywhere in the United States offer a fair solution of this problem—that is what we wish to study.

This subject, like any other of State-wide or of national importance must be studied with an unbiased mind. We must bear in mind that what may prove to be the ultimate good of the whole community may conflict with what *seems* to be a present harm to a few, and so our view relative to the problem of health insurance measures must not be a selfish personal one. We must not, as a body of physicians, lay ourselves open to the criticism that any medical opposition to such a measure is based entirely on selfish intrests. Some form of health insurance is undoubtedly a most excellent thing, but whether the compulsory feature is good, is a question.

The State Health Insurance is in force in many European countries, including Russia, Germany, Sweden, Austria and England, with varying measures of success or failure, principally the latter. In Germany, an attempt was made this year by the Social party to socialize medical practice with salaried doctors, but unsuccessfully. It is, indeed, gratifying to note that in Berlin, after a prolonged and bitter fight, the *organized* medical profession has finally procured a far better working arrangement with the insurance societies which administer health insurance there, by which free choice of physicians is assured, and higher medical fees than before. One member of the Pennsylvania Commission on Health Insurance was sent abroad to study this subject, particularly in England, and will probably have an illuminating report to make to the Commission. It is hoped that he will be here this evening.

So far, no bill on the subject has been presented in Pennsylvania. At the coming winter session of the State Legislature, it is probable that the Commission appointed by the Governor will present their second report, and it is likely

that this will be followed by a bill. If not, some over-zealous member of the Legislature, seeking notoriety, may present such a bill. We must be prepared to oppose and defeat any such a bill, if we do not approve of Compulsory Health Insurance; or, if we accept and approve of its general good to the community, we must be prepared with constructive amendments to the medical clauses of such a bill, so that the medical profession will be dealt with fairly and justly.

To give you an outline of the possible bill which may be presented, I shall quote freely from the so-called Davenport Bill, presented (and very nearly passed) in New York, because I understand that this bill is regarded by its sociological backers as a model bill for this side of the Atlantic Ocean.

The proposition is that sick benefits shall be furnished to industrial employes earning a minimum sum in wages; possibly two thousand dollars annually will be the amount set. (In Germany it is much higher). This shall apply to any kind of illness of these employes, and shall not be limited to industrial illness. The benefits shall also extend to members of the families of these workmen, including maternity illness. It is estimated that this will include from 20 per cent. to 30 per cent. of the residents of the State, and in Pennsylvania that would mean about two and a half millions of people.

It will include, if a man is sick, and unable to work, a weekly monetary benefit of from \$5 to \$10 or \$12, according to the amount of wages he is receiving, for a period of from 26 to 52 weeks. The employes are to be furnished free medical attention, nursing, drugs, medical appliances to a limited extent, dental work, maternity attention and benefits. Even if able to work, a man can, when ill, go to the doctor's office for attention without cost. In the Davenport Bill, there was also a provision for one hundred dollars death benefit.

The administration of this bill is not clearly outlined regarding its medical provisions. It was suggested in New York that the State should be divided into groups, and medical men limited to certain groups (in England they are called panels). Therefore, freedom of choice would be limited to a physician in a man's own group. However, no doctor could be compelled to work under such a bill unless willing to accept the fees offered. Quoting the Davenport Bill "the conditions of medical service and the rates and methods of compensation for physicians shall be fixed by the Industrial Commis-

sion." At a recent meeting in Philadelphia of the Pennsylvania Commission on Health Insurance, a professional investigator and agitator on health insurance was asked what he thought medical fees would be under such a bill, and his reply was that office fees would probably be from 25 to 50 cents, and for outside calls not more than \$2.

**Limitations.** Only a certain class of employes would come under the benefits; the following are specifically excluded in the Davenport Bill: Officers, managers, State and Government employes, agricultural laborers, household domestics; and so also would be excluded the small shopkeepers who work for themselves. No provision is made for the chronically ill, nor for the unemployed poor, nor the needy aged. Obviously, this is class legislation. And for these reasons not one of the charitable agencies that already exist could be abandoned.

Now for the cost of such an enactment: According to the proposition, premiums are to be divided between the employes and employers, and the cost of administration borne by the State. The estimated cost is a cent and a half to three cents on each dollar a man earned. In New York it was estimated by the opponents of the measure that it would cost the State ninety million dollars annually, and the proponents of the bill neither denied this nor attempted to controvert the statement.

In Pennsylvania, on this basis, it would cost thirty to forty million dollars annually, an enormous amount when it is considered that the benefits would be distributed to a limited class. Of course, the taxpayers would have to meet this expense in addition to paying the employers' share of the premiums which they would add to their overhead expense account as they do with the Workmen's Compensation premiums.

Now, is such a proposed enactment applied to a limited class, a worth-while measure?

Will it actually reduce the much-talked-of annual average of nine working-days' illness of industrial employes?

Can the medical attendance furnished be adequate, efficient and satisfactory?

Can it in any way improve preventive health measures?

Will it reduce the present cost of maintenance of charitable and semi-charitable agencies?

Can the possible benefits be applied at a reasonable cost, and is this cost fairly divided?



Could not the expansion of present facilities under the State Department of Health, and of local communities, fulfill far better the needs of the sickness problem?

Your Medical Legislative Conference thinks that such legislation would be both pernicious and vicious, and Dr. Bartlett and Dr. Van Sickle will tell you why. But as a member of the Pennsylvania State Bureau of Medical Education and Licensure, I cannot refrain from saying that I feel sure that medical education will be dealt a serious blow in this State if such a bill is enacted.

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#### THE EFFECT OF COMPULSORY HEALTH INSURANCE ON MEDICAL EDUCATION AND ON THE PRACTICE OF MEDICINE.

BY

CLARENCE BARTLETT, M.D., PHILADELPHIA.

*Mr. President, Ladies and Gentlemen:*

WHENEVER I see a speaker interrupt or begin his remarks by drinking a glass of water, I think of an incident that occurred in the city of Harrisburg many years ago. There was in progress a long and ardent debate. A member had spoken for three hours and then he stopped, walked over to the water cooler, and proceeded to lessen the dryness that was within him, which he did by liberal potations. When he was on his third or fourth glass, a member of the opposition rose and addressing the speaker, said, "I rise to a point of order." "Will the gentleman from Cumberland County please state his point of order?" and the gentleman from Cumberland County replied, "I believe it is out of order for a wind mill to go by water power." I trust most sincerely that my remarks will not drive this audience to drink. At any rate they will be brief.

It is hard to say why I was selected to speak on this subject for in reality, Medical Education and Compulsory Health Insurance have absolutely nothing in common, their association seems absurd. In fact, it would hardly seem as though any degree of Medical Education is necessary if Compulsory Health Insurance goes into effect.

Permit me to review the methods of clinical teaching as

conducted at the Hahnemann. We start our students in their second year under Dr. McEldowney, who spends sixty hours in all with the class, teaching them the outlines of the viscera on the body surface, and in grounding them in proper technique respecting inspection, palpation, percussion and auscultation. By the end of this time students appreciate that a chest or abdomen cannot be examined hurriedly. In the third year, the students are given two more lines of practical work. One of these is with Dr. Taggart, who teaches them how to take histories of illnesses. There they learn the many difficulties incidental to obtaining correct statements of fact from their patients, that misunderstandings may be avoided. They learn there, also, that in correct history taking it is as essential to know human nature as it is to know medical science. The same year the class goes to Dr. Williams who drills them thoroughly in physical diagnosis and teaches them how to recognize disease, both in its advanced and its earliest stages. By this time they realize the impossibility of making a half-way decent examination of a patient under forty-five minutes to one hour. They also realize that even after an initial interview of one hour, the symptoms may be of such an indefinite character that a second or third or even fourth interview may be necessary before reaching a positive conclusion; as, for example, in the earliest stage of tuberculosis.

Those who are promoting Compulsory Health Insurance contend, I believe, that it will not lessen materially, if at all, the doctor's income, in that under its provisions he will see in the course of a day such a vast number of patients as to make up for the difference in fees. In other words, the doctor will live on quantity and not on quality production. I have been informed that under the provision of the law, an office fee will be about 23 cents, and a visit to the house, somewhere around 38 cents. Under modern scientific methods, the amount of work that a doctor can do in a day as to numbers is exceedingly limited. If Compulsory Insurance should become an accomplished fact, our methods must be changed rapidly. No longer can we teach thoroughness. Perhaps we shall be obliged to teach certain methods greatly in vogue forty years ago, and, I am sorry to say, to a certain extent, found even in the year 1920. A good example of this kind of practice is found in an office in which I substituted right after graduation, and for which work I was paid \$4.00 a day. The

doctor had a large office practice and a 25 cent fee. Everything about the place was arranged for speed. Medicines were already fixed, prepared for placing in packages. Containers had full instructions printed thereon. One only had to select the proper container. Such diagnoses as biliousness, headache, heart disease, kidney disease and so forth were altogether too common. Patients were run off at top-notch speed. I myself, one afternoon, attended to twenty in one hour. There was one day when the doctor treated 121 patients in his office. Seriously, permit me to ask the question, were these prescriptions worth a quarter? Being on the ground, and knowing all the inner workings of the office, I can tell you they weren't worth a tinker's damn. For men like that the Health Insurance Act will be a Godsend. But to produce men of that kind, we must alter Medical Education and teach quantity production regardless of quality. What will happen to the poor tuberculous and the diabetic in the earliest stages of their illness, when it requires time to work out problems, no one but God knows. This scheme of Compulsory Health Insurance looks to me very much like using the livery of Heaven with which to disguise the work of Mephistopheles.

The uplifters and humanitarians who are backing the Compulsory Health Insurance are under the impression that it would be a grand good thing to secure for those not well-to-do good medical advice. As a matter of fact, good medical advice is seldom expensive, no matter how large an individual fee may appear to be. For example, I recall a case of a chronic illness where a patient had been under constant medical supervision, that is twice weekly, for two years, at a total expense of about \$200. This patient was subsequently cured by a high tariff physician and the total expenditure was less than \$50. In comparison with her first physician, the high tariff man was a cheap-skate.

I am reminded here of the story of a man who speaking of a dentist's skill, remarked that he pulled a tooth out in a few seconds and charged \$1.00 for it. His listener said, "That is extortion; I went to a dentist, had a tooth pulled, taking half an hour, and all he charged me was a quarter."

There is one phase of Compulsory Insurance which does not seem to have impressed the laborer or the physicians to the extent that its importance warrants. Quite recently I treated a case of encephalitis lethargica. During the course



of the illness, numerous reports were sent to the patient's employer and the company. When the patient was recovered, and the time for his insurance had expired, he was notified by his employer that his services were no longer needed, as it was not likely that after such an illness his recovery would be sufficient that he could once more be his normal self. In other words, information was obtained from me really as a confidential communication, and then utilized for the benefit of the business, to the detriment of the employee.

With Compulsory Insurance such a state of affairs is bound to be of frequent occurrence, and, in my opinion, will thoroughly justify strikes and lock-outs in the interest of sick humanity. Business knows no sentiment. Compulsory Insurance, supposed to be sentimental, will be managed by the insurance companies, and all of my hearers know their heartlessness.

There is another factor in relation to Compulsory Health Insurance concerning which I have never heard any comment, namely, that it will eventually if not immediately eliminate the human touch in the practice of medicine. We talk a great deal about the science of medicine, and there is a science of medicine, but the physician who depends entirely upon his science to the exclusion of the human factor is neither human nor practical. To a knowledge of medicine as a science, must be added a knowledge of human nature, and a knowledge of the patient in particular. Sir Eustace Smith said, "It is of as much importance to know the kind of patient the disease has hold of as it is to know the kind of disease the patient has got."

With these added qualifications, the physician becomes an artist, and practices the science and art of medicine.

It is said by the "uplifters" that it will be such a nice thing for poor people to get good treatment. As a matter of fact poor people get good treatment as it is. The means are provided. If they fail to procure them, it is from lack of knowledge or thoughtlessness, not from lack of opportunity. Within a few days, there called on me a sewing woman, who has been a patient of mine for a number of years. Her trouble was of surgical character, concerning which I thought she might obtain better advice than I could give her. I called up one of my surgical neighbors on the telephone, told him about the patient, and wound up my remarks by saying, "she is one of my favored list." The doctor replied, "all

right," and the patient thanked me for the recommendation. What occurred in my office that morning happens in hundreds of offices every morning. If I say anyone is on my "favored list" that person immediately goes on the "favored list" of my friends, and what is true of me and my friends, is true of every other doctor and his friends. Nobody need suffer for lack of medical treatment.

One of the objections raised against Compulsory Health Insurance is that it will force the doctors to do much paper work. Personally this does not strike me as very much of a disadvantage. It is an inconvenience, it is true, but it will force the doctor to practice hand-writing, which all their patients know they need badly.

As evidence of the time required in doing proper medical work and the care given patients in the hospital, I may instance my Sunday morning ward rounds at the Hahnemann Hospital. It has been my custom for years to visit the hospital every Sunday morning at 9 o'clock, and see every patient for whom the medical department is responsible. The visit is expected. Interns and nurses are ready for me with records and reports all in order. There are three wards, of twelve beds each, under the care of the department. During the week the patients are looked after by Doctors Paxson, Golden and Wells. Now I can assure you that with laboratory work completed for me, X-ray reports in, and with a ward nurse and assistant nurses and perhaps a supervising nurse, with an intelligent intern, and everything favorable for rapid work, it takes me from two to three hours to go through the wards. Some patients are convalescent and almost ready to be discharged. "What is this man?" "Oh, he is a typhoid. We are waiting for the second examination of his urine and stools." "What is this?" "A pneumonia case, just ready to go." But the next patient may take half an hour, even with all these preparations, and only last Sunday there were three patients who took two hours of my time.

To say that we should be compelled to go back to the methods of forty years ago is a thing that I am surprised that anyone should think of. I could not believe it possible that anyone should bring forth to humanity such a fantastic proposition as this Compulsory Health Insurance Bill.

**A GENERAL DISCUSSION OF STATE HEALTH INSURANCE, ESPECIALLY  
IN RELATION TO ITS EFFECTS ON THE COMMUNITY.**

BY

FREDERICK L. VAN SICKLE, M.D., EXECUTIVE SECRETARY OF THE  
MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

(Read before the Fifty-seventh Session of the Homœopathic Medical Society,  
Harrisburg, Pa., September 22, 1920.)

IN the discussion of the health insurance problem let it be known that up to the present moment there is no such thing in any State as "State Health Insurance," nor has there been passed a law known as "Compulsory Health Insurance." In some European countries, during the past forty years, there have been applied laws, known as "National Health Insurance Laws," or "National Insurance." In this discussion, therefore, it will be necessary to consider the subject from the viewpoint of an imaginary law, as at present we have only bills which have been introduced in States, such as New York, from which to deduce an opinion as to the effects, were these bills to be applied as laws in such States as New York or Pennsylvania.

It is, then, necessary for us to review the experience in European countries, such as Germany, England, etc., in the discussion of its effect on the community. Time will not permit of a thorough review, but we first find that it creates a class distinction, as all the people of a community could not or would not come under the Compulsory Health Insurance laws. We find that, if these laws were to be applied, farm laborers, those in domestic service, those casual laborers who work only part-time, and those whose health is such as to admit of casual employment only, would not receive the benefit of such insurance. Then, too, it would not reach those who are in certain types of employment, wherein the Compulsory Workmen's Compensation Act does not apply, for it would not any more apply to Compulsory Health Insurance. It would affect some, and miss others who would be equally in need of such protection, if it be of value. It would not give continuous benefits, as after twenty-six consecutive weeks, the payments for the physician, hospital, nursing, medicine and supplies, as well as cash benefits, would cease, even though the sick man had not fully recovered. Indeed, it is this serious fault that the pro-



ponents of this measure point out, admitting that it is not what insurance of this type should be.

Were the same plans to be followed as in other countries, it would divide the community into districts of (quoting the New York State bill) "persons whose earnings shall not exceed twelve dollars per week," each district to consist of 1000 to 1200 persons, composing a local or trade fund, known in England as "Friendly Societies." These local funds organize by electing a board of directors of seven members, all laymen, four of whom will be employes and three employers. "They shall make rules and regulations for carrying out the purpose of the fund," viz., hiring the doctors, nurses, designating hospitals, and in fact all of the provisions to furnish relief in case of sickness, and beside to arrange so that the members of the fund shall have furnished to them "free choice among all regularly qualified physicians, subject to the right of any physician or surgeon to refuse patients." This plan is known as the "Panel System" in England. The rates provided for such service in other countries, were they to be the same in this country, would not make it possible that adequate medical service could be rendered.

In so recent a report as last month, German papers, such as the Medical Clinic of Berlin, comment on the matter and apparently admit that the system in vogue in Germany has practically reduced to State servitude a formerly free and independent profession. It further remarked that negotiations for renewal of contracts were abruptly broken off when fees of twelve marks for house visits and eight marks for office calls were suggested. At the present depleted value of the mark this would be about twenty-five and seventeen cents respectively in American money, and laying aside all question of the present condition of foreign exchange and the purchasing power of the mark, the real significance of this report lies in the fact that private practice in Germany has become almost a thing of the past, and that the State has virtually assumed control of the practice of medicine. We infer that if, after forty years' trial the physicians are dissatisfied, as they always have been, we cannot but infer that Compulsory Health Insurance would develop inferior medical protection and service for the people of this State, were we to have such a law. The rates for medical service are fixed by the bureau, which

has full power to determine what kind of service the people should have, and what should be paid for that service.

The physicians of every community in this State are striving to furnish the best medical service possible, a friendly rivalry existing as to good attendance and scientific treatment, and the effect of such restrictions as would be placed upon medical men by Compulsory Health Insurance would be to reduce the incentive to offer the best service possible.

The earlier experience of the application of mass insurance, such as was found in lodge practice and societies which employed physicians by the month, is to a certain extent analogous to this type of insurance, and brought results which, to many physicians, illustrated what has been found in Europe, known as malingering. The subsequent effect upon the people has always been, as proved in European countries, to foster a tendency to this evil, if the sickness is being treated by physicians who are paid out of funds created either by assessment or in other ways, where the individual does not pay for such service directly. Especially is this found in times of labor depreciation and lack of work. It is so much easier to stay sick, draw benefits, call the doctor, and keep him coming, than to seek a new job.

It is at that time we see the most fatal side of this plan of insurance, and when we consider the enormous amount of money which must be raised by assessment upon capital and labor, as well as the State, in order to apply this type of legislation under State supervision, we might hope for some good to come out of this insurance plan were all such funds to be expended in purchasing relief or cure in sickness, or in sickness prevention. But this is not the case, as it has been proved that not more than 50 to 60 per cent. of this money would reach the sick man or his family. Overhead costs would use up the remainder, in the application of the law. Even then, if the death rate from disease could be reduced under this plan, or if the reduction of sickness in the homes of the laboring class could be accomplished, we would, out of a proper sense of our duty to the public, be the greatest proponents of this law. But we know that these reductions will come only by the application of the laws of health, which the science of medicine of the past has worked out, and which the science of the present and future is working out, and which the medical men and women of the State will continue to prove

as being of value in the sickness problem. It is our duty not only to treat people when they are sick, but to aid in every way to teach them how to keep well. This plan would become obsolete under the Compulsory Health Insurance law.

Why do we as physicians presume to discuss the effect of compulsory Health Insurance laws upon the people of the community? We have tried to view measures which affect the people, in which physicians are concerned from the point of view of impartial advisers. We have abrogated to ourselves a duty, from the earliest days of medicine, to act as our brothers' keepers, or to state it better, advisers in matters regarding the preservation of health, or health measures. This, then, is one of the times when we believe it our duty to combat a danger of error in accepting a theory that this plan of Compulsory Health Insurance would solve the sickness problem. It would only complicate the matter of treating the sick, and the future would be worse than the past. Any State that becomes over-officious in the application of paternalism, is doomed to reap the reward of increased demand for *free* service on the part of the people to whom this free service is extended. This is well exemplified in Europe, in the national insurance laws. We cannot, therefore, recommend paternalistic insurance in this State as beneficial to the people in industry.

If we consider that the physicians are part of the community, a part of the business of the community, then we must view also its effect upon them in the discussion of this problem. The young men of the past have had in mind, and I presume those of the future will have in mind, some idea as to what a career in medicine means. They studied the lives of the doctors in their vicinity, and deemed it a profession well suited to their taste. I might ask each one of you, if, when you attended medical college, you did so in order to practice medicine just for pleasure alone? Maybe you did, but I doubt it. Again, I might ask you if you toiled from four to seven years in order to be prepared to treat the ills of the human family, and did so only for the money you were to receive? Again I would say maybe you did, but I doubt it. You did, however, conceive the idea that the practice of medicine would give you an opportunity to earn a reasonably competent livelihood in a profession that would not only give you pleasure in relieving the sickness, pain and suffering of your patients, but would give you a vision of the good you might do for the



future of your patients and their families in advice and counsel regarding hygiene, sanitation and the prevention of disease.

With these ideals in mind as we review the effects of the laws of Compulsory Health Insurance upon the community, we would ask any layman if he would consider the future in medicine enticing, and would he believe that we would welcome a time when class distinctions among physicians were brought about by this type of medical practice, whereby the physician who is chief of the bureau and the medical officers of the funds would have a superior authority over all other physicians in the every-day practice of medicine. Do you think this would foster a personal relationship between doctor and patient, and would the people receive better medical care when frequent disagreements occurred between the panel and fund physicians and the medical officers? Would a supervisorship by lay members of the funds over the "panel" physicians tend to make the doctor do the very best he could, without due appreciation as to what good medical service meant?

These are some of the questions that the proponents of this type of legislation do not discuss. They tell us that it will shorten the sickness absenteeism from the now average nine days' loss and its loss of income, under compulsory health insurance. They assure us that it would shift the burden of sickness from the poor laboring man upon the shoulders of those who are able to bear it—namely, capital. They assume that much of the previous effort by those who have built up a relationship between the public and hospital service, dispensaries, etc., was expended from a wrong viewpoint. They do not believe that the sacred relationship between the physician and the patient is of value; the drawing of hard and fast lines of legislative control is the only way to manage the sickness problem among industrial workers. In England the advocates of this type of insurance consider it wise for the Government to think for the poor laboring man, and believe that his sickness worries would cease, due to kind care of the State in giving him all necessary attention for himself and his family. The laboring man of this State, however, must have it pointed out to him that he is to share the expense of this insurance in a fifty-fifty proportion. Were he to be treated in sickness, and receive sickness benefits, he would then be getting service of a type that could or would be rendered on a basis of 50 per cent.

inferior or neglected service, as the other 40 or 50 per cent., we assume, would be used in paying overhead costs of the application of the law. Would this be good for the laboring man? Would it be a profitable investment, or would it not be better for him, if the State wished to conduct sickness insurance, that the money so raised to pay for sickness benefits should be paid to him, allowing him to select his physician as heretofore. This would be more equitable to both the workman, the doctor, the hospital, etc., business would not be disturbed, the friendly relationship in the sickness problem would not be taken away, and a guarantee of proper service would more surely be possible than under the plan of Compulsory Health Insurance.

During the past year this subject has been much discussed and much written upon in Pennsylvania. These discussions were stimulated by the fact that Pennsylvania has a commission now studying Compulsory Health Insurance. We consider it a duty to ourselves, as well as to the people of this State, to make public such facts as bear upon this measure, believing that no law should be made wherein so many people are to be affected as would be, were the commission to find it their duty, or rather their desire, to present a bill during the coming session of the legislature in favor of Compulsory Health Insurance.

We have pointed out the effect upon the people, where this type of insurance has been applied in Europe. We have also pointed out its effect upon medical practice. It is no assumption on our part, but a fact, that no plan or scheme of this kind has been of benefit to anyone affected by the law, and has only proved that State control does not lead to the best results in giving that which the law is supposed to give—namely, good medical service in the relief of sickness. We believe the Commission should have, in no uncertain terms, the views of the profession, protesting against the interference with the people's right to select that kind of service and the particular individual in whom he may have faith when he is sick, or needing medical service. These he cannot have under any plan proposed heretofore in Compulsory Health Insurance.

We can only appeal in a fair-minded way to the Commission to remember that there are so many other ways in which the people of this State can receive from the State aids

toward better sanitation, better regulations in hygiene, that there are better methods of reaching those who are unable to fully pay for medical service, than by adding to the enormous number of laws upon the statute books by such a burdensome one as Compulsory Health Insurance.

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DR. PIPER: Now I know that you will be delighted to hear from Mayor Ramsey, of Chester, who has just returned from a trip across the water.

ADDRESS OF HON. WILLIAM T. RAMSEY.

MAYOR OF CHESTER AND CHAIRMAN OF THE COMMISSION.

*Mr. Chairman and Members of the Homœopathic Medical Association of Pennsylvania:*

FIRST, I want to apologize for coming in right in the midst of the meeting. I have returned home to find my police department upside down, and it was necessary for me to hold a trial of two policemen this afternoon. I could not, therefore, get away in time to be at the opening of the meeting.

I am not prepared, having been home only about two weeks, to lay before you the detailed report of my trip in Europe—or in England, particularly—studying the Health Insurance proposition. I was listening very earnestly to the address of Dr. Van Sickle. Several things that he mentioned are of vital importance in connection with the study of this question. He seemed ever to keep before you the fact that a certain bill or bills were contemplated and were in course of travail throughout the State. If there is such a bill, it was prepared while I was away; so I could not discuss any particular proposition. I want to say, however, that there are two things in my mind as a layman (and I am speaking particularly as a layman, without any other profession except that of the Mayor of the City of Chester); and they are: Prevention of sickness and its cure. These were the two big things that were in my mind, and are still, even after I have spent five weeks in England, Scotland and Ireland, studying that British Compulsory Health Insurance Act.

In addition to that, there are certain conditions that differ materially in this State from those in Great Britain. These must be taken into consideration, if a fair comparison is to be drawn between Compulsory Health Insurance and Non-



Compulsory Health Insurance. These conditions we had to take into consideration. I say "we," because there accompanied me a gentleman who was and is an expert investigator; and that gentleman is now preparing the detailed report of our trip abroad, which I wish to assure you, gentlemen, will be prepared in an unbiased manner as to whether we are advocating or not advocating Compulsory Health Insurance. We endeavored, by our study abroad, to lay before the medical profession—because I believe that this is the one profession and the one class of people in Pennsylvania who must be taken into consideration more than any other class; and I exempt in that statement the working classes, because Compulsory Health Insurance will, in some measure, help the workingman. But the doctors are the men who must be considered, and to my mind, more than any other class; and I believe that this Commission, of which I have the honor to be chairman, has that in mind. We are endeavoring not to do anything without having the advice of medical men and the benefit of their opinion on this.

You men all know why this Commission was appointed, and also know that since the Compensation Act has become a law in Pennsylvania, there has been, at every session of the General Assembly, more than one bill presented that endeavored to extend the scope of benefits to the working men through compensation to provide for sickness. Due to that fact, I believe, more than to anything else, the Commission was created in 1917, and for two years studied the question in relation to the conditions in Pennsylvania. The Commission worked earnestly, and gathered together a considerable amount of material, in spite of a limited appropriation, thanks to all of the various units of people interested, who gave us their services free. We had not come to a conclusion in the first two years' study, either, that we could recommend a bill or that we were, in our own minds, satisfied that it was not a matter for consideration; and we asked the General Assembly to continue the Commission and enlarge its scope of study, to the effect that a survey of existing laws might be made. There were none in this country, and the nearest country that we had in which there were any such laws was Great Britain. To that extent, the General Assembly advised a ratification and approved the proposition that a study should be made abroad.

I want to say again, in all fairness to Compulsory Health

Insurance, that up until our report comes to you, it is my opinion that there has not been a fair, impartial survey or recital of the Compulsory Health Insurance Act as administered in Great Britain given you men in Pennsylvania; and it is our hope that we shall, first of all, present to you a report of the conditions of health insurance as we find them in England. After that has been given you, I believe that the Commission will not arbitrarily do anything until the fair thing has been done in this country, which was not done in the original draft of the Act in Europe; and that is, that all those vitally interested, beginning with the medical profession, have had a chance to express their views. By the way, a doctor in my town said to me today, "Bill, you have not called the proper doctors to help you in this investigation." I said, "We have asked the medical profession of Pennsylvania to name their own representatives, and they have done it." "Yes," he replied, "but you have the specialists, and have not the general practitioner on the Health Commission." "That is no fault of mine," I said, "If the medical profession did not select you, but selected somebody else, it is no fault of ours." It seems to me that the men who are particularly interested in this proposition are the ordinary, everyday practitioners. Those were the men that we spent days and nights with in England. The men who, in Great Britain, before its inception, opposed it, are the ones who today are the advocates of National Health Insurance. There is, however, no unanimous opinion on the subject in Europe; because we found a body of sixteen hundred practitioners and medical men who had banded themselves together in a labor union and had become a part of the Labor Union of Great Britain, and who were opposed to Compulsory Health Insurance and set up their standard in very beautiful colors. Yet when they were asked this question: "Would you repeal the Health Insurance Act in Great Britain?" they, with one accord, replied, "No;" and I want to say to you men and women that every group of men that we discussed this great question with in Great Britain, whether they were for or against, and particularly if they were against the Act, they did not present anything to take its place. That is what we found in Great Britain. The medical profession of Great Britain answered to my satisfaction two important questions to me. One is that the Compulsory Health Insurance Act of Great Britain, although

at its beginning it has passed through a war of four or five years' duration, and more war than we have ever seen over here. Conditions are worse in Great Britain than here, the air raids having produced a nervous feeling among the people of England, particularly in and around London, that has very naturally increased the amount of, shall I say sickness? But it has increased the necessity for the medical profession in Great Britain to feel, perhaps, that they are entering into a new condition, even worse than it was when this Act was first placed upon the statute books.

I am glad to be here. There might be other things that I could go on and recite; but I want to, first, as Chairman of the Commission, assure you men that we, the Commission, and you, the doctors, have only one thought in mind for Pennsylvania. If I were talking to a convention of manufacturers, I should say the same to the manufacturers of Pennsylvania, that so far as Health Insurance is concerned, we, the Commission, and you, the manufacturers have but one thought in mind. If I were talking to a body of labor unions, I should say the same thing to the labor unionists; and that one thought is this: Whether or not Compulsory Health Insurance in Pennsylvania will produce a particular effect that will keep the laboring man longer at the bench, and produce a better feeling between the laboring man and the manufacturer or the employe and the employer, is of no great importance; but whether it will create and produce a healthier Pennsylvania.

Now that same thought was in the mind of the Government of Great Britain when the Act was first proposed. Conditions there were not as they are now. Conditions there were not as they are here; because you probably realize that when the Act was first passed in Great Britain, there were thousands who could not purchase medical attention. The State, in order to relieve such a condition, proposed this Health Insurance Act, with every medical man, almost, against it. But that has been worked out to this end, that the Government of Great Britain are amending the Act from time to time. They passed two or three amendments while I was in England. I had the pleasure of sitting in Parliament while the amendments were passing through. They were amendments proposed by the medical men or by the working people. They were improving this Health Insurance Act of Great Britain; and while I must say truthfully that the Compulsory Health In-



insurance Act in Great Britain is in no way perfect, it seems that the least that we can say of the people over there is that they are endeavoring to make it do what it was intended to do—and that is, produce a healthier England.

The greatest objection to it on the part of the insured is that there is a discrimination in practice, in medical service. I was led to believe that Health Insurance in Great Britain had placed medical service in Great Britain so far below par that it was absolutely unworthy of thought. I believe tonight, from my survey among the medical men, that it has not done that, in a general way. In particular places, it might be so; but I do not believe that the man who is a doctor, the man who is practicing medicine, would ever permit a Compulsory Health Insurance Act to lower the standard of medical practice, particularly if he was a Pennsylvania doctor. It has not done that over there generally. It may have done it in spots, and I believe that I might say this about the conditions over there: In the beginning of the Act some men may have gotten into the work who were not of the highest standard. Since that time, the medical profession of England have been working out and helping the proposition, and I am sure that health insurance, even Compulsory Health Insurance, has not lowered the standard of the medical man or his practice in England; and, judging by the waiting lists in the medical colleges of Great Britain, it has not prevented the young men of Great Britain from entering the study of medicine, and becoming practitioners of medicine there. That is the impression that we received from the medical profession and the statistics of the colleges where they teach medicine, so far as the students are concerned. I thought, when I went over there, that no one in Great Britain would study medicine any more; but I am sure this is not the case.

I do not know so much about the medical practice in Pennsylvania, except as I have observed it from membership in the Legislature and what I know of the doctors of Pennsylvania; but it seems that they have so many different classes over there. They have the practitioner, the consultant, and the man higher up. All are in some way linked into the Act by amendments, as passed from time to time; but the conditions are so different that it is hard to make a comparison between Great Britain and Pennsylvania in regard to the administration of an Act, should we have one in Pennsyl-

vania, and the working out of the various conditions of Compulsory Health Insurance. It is being extended in Great Britain now. The thought is, perhaps, to extend it to the families.

I sat one night in a doctor's office, without any knowledge on the part of the doctor that I was present, to observe whether or not this particular man showed any discrimination between the panel patient and his private patient. Of course, to my untrained eye, perhaps, he showed no difference whatever. He told me he had in the office a large number of panel patients and a large number of millionaire patients; and to my observation, he treated both alike.

I sat another evening in the office of a physician who did not treat both alike, perhaps discriminating a little against the panel patient. I also studied the question from the point of view of the fellow who received the benefits; and he said that all he knew was that he paid in a sixpence and did not get enough out. That was the thought of the man who received the benefit.

We studied it, beginning at the bottom. The first people that we interviewed were the workingmen. The people that we paid the most attention to—because we could not help it—were the medical men; and we spent some very pleasant hours with members of the British Medical Association. We spent pleasant hours with those opposed to the measure; but when it was all summed up, no one wanted to repeal the Health Insurance Act of Great Britain.

But most of all my object in making a field report of conditions abroad is that you men shall be able to rely upon what this Commission gives you; because we did not go there to make a case out of it. We had no particular desire to make a case for or against Health Insurance. That is why we are anxious to have Pennsylvania represented by its physicians, by its labor unions, by its nurses, and by all those who are interested. I do not believe that this Commission is going to force anything or any conditions upon the people of Pennsylvania until we are certain that Pennsylvania needs it; and that when that time comes, you men are certain that Pennsylvania needs it.

I thank you, Mr. Chairman, and the members of this Association; and I am going to ask you to wait until the report is presented and see what the condition is going to be.

DR. PIPER: We have twenty-five minutes remaining for open discussion, and I am going to call on Dr. E. S. Snyder, of Lancaster, to open the discussion.

#### OPEN DISCUSSION ON PAPERS ON COMPULSORY HEALTH INSURANCE.

DR. E. S. SNYDER, Lancaster: *Mr. President, Honorable Chairman of Our Pennsylvania State Commission, Ladies and Gentlemen:* The people of this State are facing probably the greatest crisis of modern times, in that society, from an agricultural and labor standpoint, from a commercial standpoint, from a banking standpoint, and from any angle at which we may view the situation, we are facing a great crisis. The medical profession are spending an hour or two tonight in a consideration of a question which means that they are up against a crisis.

Great movements sometimes steal insidiously upon us, so that we hardly feel their approach. I want to refer you to an address that was read in about the year 1904, which was made at the Commencement Day Exercises of the Edinburgh University, by one of the professors there. He said, during his address, "I want you to turn your eyes to America. I want you to look over to the United States. If you will size them up, you will find that they have the greatest resources at their command of any country in the world. If you look into their mineral deposits, you find that there is great abundance of gold and silver there, that there is iron there, that there is lead there, and that there is copper there; and that their growth of lumber is beyond any comparison in the old world. Back of that, they have the greatest artisans ever known; and if ever there should be trouble between this country and ours, it would be all day with us; because they could enclose themselves with a fence and defy the armies of the world."

Do you mean to tell me that they were not thinking, just as the little boy sizes up the other boy, that he would like to whip, that they would like to whip us? They were measuring us; and from 1904 to 1914, there was not much in the way of peaceable communications that went on between these countries; and I want to ask you, Honorable Mayor Ramsey, whether you had a medical expert with you in connection with the gathering of your testimony?

MAYOR RAMSEY: No.

DR. SNYDER: I want to say that in 1883 Bismarck introduced in Germany the idea of Compulsory Health Insurance,



thus introducing paternal socialism, and we all know that paternal socialism causes death of individualism. I want to say that he had this idea back of it, unseen by the people of that day. The people of Germany were taken care of medically from that day to this. In 1914 it was transplanted from Germany to England; and I believe that it was there destined to have it grown in that way; because if it had not been for the United States, which sent American physicians to England, during the World War, what would they have done? They had to draft men to help them; and if we had been prepared for this war, which was so insidiously stealing on the world, perhaps we should not have had to shoot a gun or send two million men over there to fight.

We must wake up to this situation. We have to go farther than the expert tells us. We have to weigh these matters. We are today facing a crisis here in Pennsylvania. It must be met by us. We must anticipate what is going to happen here. We cannot wait until the battle lines are drawn, with all the implements of war directed against us.

We may gather from the remarks made that they have drawn classes over there; that the panel physicians are a group by themselves, that sixteen hundred others are in another crowd, and that there are still some others higher up. Would you like to have the medical profession here cut up like that? Would it enhance the dignity of the science of medicine? Would it promote research work? Not much. We do not want to have the Continental castes or classes in this country.

Of course, they are satisfied.

That is, Continental Europe that is going over to England. They have always had classes. You can go over their doctors, and even in the islands of the seas you will find caste and classes; but I want to tell you again that that is not American. That is not what we want. We want to be practitioners of medicine, and not have to sneak in at the back door; and I want to tell you that that is what they are doing in some parts of England today. Compelled to go to the side or tradesmen's door. Am I right, or don't you know? Honorable Sir (Mr. Ramsey).

MAYOR RAMSEY: I do not understand you. You will have to be plainer.

DR. SNYDER: I said that there are certain places in England where the doctor has to go to the side door to get in. The profession is so demoralized that they now stand for almost any imposition by the public.

MAYOR RAMSEY: It always has been demoralized. The Compulsory Health Insurance Act has not made it worse.

DR. SNYDER: They are still more demoralized. If you lay the proposed laws before the intelligent medical profession and study them, there is no American man who would want them. We do not want men higher up or a labor organization to govern us in the performance of our duty from day to day. I want to tell you that health insurance is practically a new problem to us. Unlike other insurance, it is so new, we do not know much about it, and that is why we are studying it. In Austria and Russia, the mortality rate has increased 100 per cent. since they had it in force. We are looking to the welfare of this country. Would it be to its welfare, if we increased the mortality rate and slackened the incentive for medical study? We do not want Bismarck to rule us. We want to stand on our own bottom. It is up to us to study this proposition for ourselves and make a thorough analysis of it. It is up to us to do it. We have got to do it; I mean the professional men, who understand their own business better than any other men can.

Now, so far as the cost is concerned, in my analysis of the situation in Pennsylvania, I find that there would be four millions of people, rather than two and one-half millions, that would be affected; and that it would necessitate an expenditure to supervise—and that means only to supervise, because we are expecting the employer and the employe to go fifty-fifty—sixty-five millions of dollars annually. That is what it will cost the people; and the employer will not only have to go half with the employe, but also pay his private taxes, to help make up the sixty-five millions of dollars.

Now we do not want any classes here. It is probable that in Pennsylvania—at least, it has been suggested that not all would receive benefits from this law; and the effect in Pennsylvania would be that any person that would be earning from one dollar to sixteen hundred dollars a year would be entitled to free medical service, and those above that would have to find their own medical service. It has also been suggested that men in positions of authority would not come under the beneficiary class. Therefore, you would have two strata of people. We should have class legislation, which we have been trying to avoid. Are we going to turn our backs on these fundamental principles of our forefathers, who studied so hard to formulate them? They were said to be, by the best minds of the world, the wonder of their day. We do not want Continental caste nor classes, but to take care of our own medical profession. It is probable that these panels, distributed over the

State of Pennsylvania, would be about two thousand in number. That would mean accession of two thousand men from the professional class to the position of lodge doctors. In addition, it would take 8,000 people to supervise and govern these panels. These men would be laymen, and you would find that the profession, in so far as relates to health insurance, would be governed by laymen. In other words, it would be in the hands of the log-rolling politician; and the thought is that the work would be contracted out—that the Government would not set a fee, but that every community would set its price by auctioning it off to the best bidder. I do not believe that this would be done. Pennsylvanians would not stand that, but they would stand log-rolling. There would be positions to fill; and we, as a medical profession, do not want that. We want to govern ourselves.

We have taken care of the poor and needy, and those who have come to us have not been turned away because of not having money. I am sure that everyone in this room takes care of charity patients. If we get together intelligently, we can control this situation. I believe, as this honorable gentleman has said, that they are not trying to put anything over on us as a profession. They are in earnest; but sometimes their good intentions do not make up for their shortcomings, and I feel that the medical profession can best protect itself against the invasion of such insidious laws as this and decide for such laws as are proper to put on our statute books.

These questions have been brought before us because of certain special elements in this and other States. This is not the first State that it has been tried in. I can tell you of propositions put before eight or nine States. I can tell you how they were handled and how they were beaten. They were short only two votes in the New York Legislature. They tried to pass it again, and withdrew it because they thought they would be defeated. In California they were beaten by over 100,000 votes because the medical profession spent \$35,000 to do it. This is a live issue in all the States, not only in Pennsylvania. We represent this grand Keystone State, and we are not going to have anything put over on us. The way to prevent it is to prepare for war in times of peace, and that is what I meant when I recited the story of that old college professor's statement in 1904. And now my twenty-five minutes allowed to speak is exhausted, although there is much more to be said on the subject. I thank you all for the interest you have shown.

MAYOR RAMSEY: Mr. Chairman, will you permit me, before any other man speaks, to say something? We did not



have a medical man making the investigation, but we had a Pennsylvanian; and I want to say something that came to my mind over there. All the hospitals in Great Britain are almost bankrupt; and in my study of this question, very naturally, the thing that is close to my heart is the amount of money that the State of Pennsylvania contributes, each year, to the support of its hospitals. I am in favor of its continuing appropriations to hospitals. They have not had it in Great Britain, and are afraid to begin it. They are working now on some form of assistance by the State. The medical profession of Great Britain, when I asked them how they felt about it, said (meaning the men who represented them), "If the State were to subsidize the hospitals, then we doctors would not give our services free." I said, "The State of Pennsylvania subsidizes its hospitals and every medical man in Pennsylvania gives his services just as freely where the State is assisting the poor as he would do if it was voluntary." They said, "Is that true?" "Why, of course it is true," I replied; and I believe that they are commencing to think about Pennsylvania, and that it will not be long before they will send over a commission to Pennsylvania, to see how we do things here; especially how we are able to get our doctors to serve in the hospitals every day free, where the State helps the poor patient. I was not a medical man; but I believe that every opportunity I had to compare the difference between the medical people and the Government of Great Britain and the medical men and the Government of Pennsylvania, I did it. They have some wonderful schemes and splendid men to work them out, and I believe that medical men of England will make this Act one to be proud of. There is no need to have Bismarck or the other fellow with the turned-up moustache have anything to do with Pennsylvania.

I went to France to see the battle fields, and they told me that we did not have any fighting men over there. I got mad, and that saying became so much of a by-word that around the hotels, one man would stop another and say, "If you want to get a rise out of Ramsey, just say that there were no American soldiers fighting in France." I told them over there that if the men in the United States had not been drafted to assist them, they would probably not have gotten through with it; but you want to remember that these people had war a long time before we went over. If we had been prepared, there would not be twenty-five thousand men lying in a cemetery over there, as there are now.

I have been a Pennsylvanian over there. I have got into many a scrap in Great Britain over Pennsylvania. There was

no other State in the Union than Pennsylvania; and the rest of these States presented their bills after a partial investigation, but Pennsylvania will not present a bill until they have all the information, in order to lay it before the people of Pennsylvania, so that when it is done, it is done right. That is the way we are going to do it in the future in Pennsylvania.

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DR. G. HARLAN WELLS, Philadelphia: We are not here tonight to present any extended argument, but I think that the Commission is desirous of knowing the opinion of the members of the medical profession of this State. The Chairman of the Commission has said that he feels that the medical men are the *first* to be considered. I think that this is only indirectly true. The thing to be considered *first* is whether the Public Health Insurance Act will be for the benefit of the *people of Pennsylvania*, and the medical profession deserves consideration only in so far as the workings of this Act will tend to make the medical men do better or less efficient work. The primary thing to be considered is the welfare of *all* the people of this Commonwealth, and not merely the laboring class. While we have no Act yet presented in Pennsylvania, we can only argue from the Act presented in New York that it is class legislation; for it is applicable to only a small part of the population of the State, whereas everybody has to pay the bill. It does not matter that each has to pay only a certain percentage, because in the final analysis the consumers, the general public, pay the entire bill. We all know what happened to our coal bills when the miners got ten cents more for loading coal. We pay that, and more.

The question that has been raised by the Commission, very properly, is this: Will the Act produce a healthier Pennsylvania? I think that we can say positively, "*No, it will not!*" I say this because it will have nothing to do with prevention of disease. It pertains chiefly to people who have become sick. If 25 per cent. of the \$60,000,000 that it will cost to administer this Act were expended for educational measures and in assisting the work of the present Bureau of Health in the State, we could reduce the amount of disease in the State considerably. It does not matter, after a man is sick, who pays the bill; because the body economic has to carry the burden of his illness in the long run. But if we can prevent the man from getting sick, we have reduced the burden by just that much; and it was the consensus of opinion at the Medical Conference that the proper substitute for the proposed Act is an educational campaign in this State by means of the

agencies now existent and those yet to be formed for the prevention of disease.

There are thousands who can get no medical attention, as has been said. I have talked with a great many medical men on this point. I went up to the manufacturing district of Kensington, in Philadelphia, and asked the men there, "How many people do you know who are sick because they cannot get medical attention?" The unanimous opinion was that there was not 1/10th of 1 per cent. of the people suffering because they could not get medical attention. Why? Every doctor treats lots of people without a fee, and the city of Philadelphia pays a physician in every ward to attend those who have no money to hire a doctor; and in every ward there is a hospital or a free dispensary, where they can go and get medical attention without expense. The number of people suffering from lack of medical attention is practically negligible.

As to the state of satisfaction of the medical profession in England and Germany over the workings of the law, I can present no facts except in so far as I can gather from representative medical journals of these countries. When the act was proposed in England, the medical profession were violently opposed to it and refused to serve under the Act. The Government passed the law. As to whether they have become satisfied since, I cannot express any opinion, except that the views in *The Lancet* and the *British Medical Journal* indicate dissatisfaction. In Germany, the profession is absolutely disrupted, and is in a state of inefficiency in every respect.

In order that the Commission may have definite information as to the opinion of the 800 members of the Homœopathic Medical Society of the State of Pennsylvania, I would offer the following resolution:

RESOLVED, That it is the opinion of the members of the Homœopathic Medical Society of the State of Pennsylvania that the passage of an enactment providing for Compulsory Health Insurance would be imposing a useless and unnecessary financial burden upon the people of this Commonwealth, would result in inefficient medical service to industrial workers, and would lower the present high standards of medical education and practice.

It was moved and seconded that this resolution be adopted. Carried unanimously by a rising vote.



**COMPULSORY HEALTH INSURANCE.**

BY

THOMAS H. CARMICHAEL, M.D.

(Read before the Homœopathic Medical Society of Philadelphia County.)

MORE than any other profession, that of medicine is oblivious to movements, legislative and otherwise, that affect its vital interests.

If physicians would act as a unit the public could be educated in matters medical and the enactment of ignorant legislation could be prevented. Such laws when once established are seldom or never abolished. At the present time the prerogatives of the physician are threatened as well as all incentives to individual scientific work in medicine by the adoption of what is called Compulsory Health Insurance.

The history of this movement is a peculiar example of perversion of purpose, for it was advocated by Bismarck in 1883 as a means for more thoroughly solidifying the German people in acquiescence to autocratic paternalistic rule, but it has been one of the principal agencies in the removal of the last vestiges of that same autocratic, monarchical government and in the development of the present Socialistic regime. As a purely Socialistic measure of German origin it is now seeking admission into the United States and is knocking at the doors of our State legislatures. In some of these, bills have already been introduced or are in process of formation which provide for the obligatory insurance of all workingmen and women whose wages amount to less than \$1200 per year.

These bills vary in detail but usually provide that the insured shall have all "necessary medical, surgical, nursing and dental service, medicines and appliances and a cash benefit amounting to two-thirds of the weekly wages of the insured for the period of illness up to six months." These benefits are to be paid for as follows: The cost to the employe averaging about one and one-half per cent. of his wages, the employer pays an equal amount, and the State pays one-half of this amount or one-fifth of the total.

In searching for the best means for the presentation of so involved a subject within the limitations of this brief paper, it occurred to me that I could do no better than to present, in a

condensed form, the best that can be said in favor of Compulsory Health Insurance, and then to consider what may be said in their refutation.

For this purpose I have selected a short article by Irving Fisher, entitled, "Compulsory Health Insurance," in the *Living Church*, of April 10, 1920. Now while Irving Fisher is Professor of Political Economy in Yale University and one of the most distinguished writers upon this subject, I do not find that he claims to be an expert upon insurance or that he has specifically fitted himself to speak as an authority upon compulsory insurance.

Prof. Fisher says, "The one great aim of the advocates of compulsory health insurance in the United States is to aid in a practical way the standard of physical well-being of the bulk of our people." Referring to Germany he says: "Whatever we believe about the motives behind her government, it is generally conceded that, during the last thirty years up to 1914, Germany enjoyed wonderful industrial progress, increasing freedom from poverty, gradual reduction in her death rate, advancement in hygiene and in the physical preparedness of her soldiery. Part of this progress is presumably due, in considerable measure, to health insurance."

"The advantages of health insurance accrue to the employe, his employer and the community in which he works. The most obvious advantage is to the employe in the partial indemnification against serious loss and hardship to him and his dependents in the case of his illness." That he "needs this indemnification far more than does the capitalist; first, because the sickness rate is two or three times as great among working people as among the well-to-do; and, second, because in the majority of cases the income of the laborer has scarcely more than equalled his necessary expenditures and has left little margin with which to secure necessary and timely medical aid. Timely aid made possible by insurance not only relieves the financial strain by cash benefit, but decreases the loss by checking the disease and by preventing bad after effects or the spread of the disease among fellow employes. This means better health in the long run to the employe, better service to the employer, and decreased sickness in the community."

In addition to these more direct and obvious advantages, Prof. Fisher claims that a number of indirect advantages

grow out of them. He says that health insurance will bring about better sanitation, ventilation, and lighting, more physiological hours of labor, and fuller consideration for the needs of employed women and children.

Health insurance in Germany has operated to stimulate the general scientific study of disease-prevention. In the United States at present in contrast to health-insured Europe we find an increasing death rate after middle age.

"According to the calculations of the National Conservation Commission at least 42 per cent. of the deaths now occurring in the United States are unnecessary, that is, over 630,000 lives could be saved annually." (The inference must be—saved through compulsory health insurance.) The death rate from degenerative diseases in the United States' registration area has increased 41 per cent. in twenty years. (Here again we are to infer that compulsory health insurance would greatly diminish or eliminate this factor.)

Prof. Fisher closes his paper with the argument that health insurance should be compulsory because "only 5, or at most, 10 per cent. of workmen in the United States needing insurance actually have it—that the other 90 or 95 per cent. have been deterred by the high cost of such insurance under the voluntary system, by their lack of appreciation of its benefits, by the inertia of custom and by the sheer desperation of poverty," and the voluntary insurance, as shown by the National Convention of Insurance Commissioners in their examination of the fourteen principal companies writing health and accident insurance, costs three to four times as much as that of the compulsory system of Europe. This is a fair although condensed presentation of the claims for Compulsory Health Insurance. You will have noticed that the medical profession is not even mentioned as being concerned in this radical departure from existing methods of insurance. It is questionable that it should be called insurance as "it is rather a measure of taxation, of compulsory levies upon both labor and industry amplified by ever increasing grants in aid or financial subsidies on the part of the State."

Statistics will show that during the thirty years of compulsory health insurance in Germany the standard of physical well-being of the bulk of the people of the United States under free, individual, voluntary methods has more than equalled that of the Germans. The wonderful industrial



progress of Germany has been more than matched in this country. We have never had under our free institutions the pauperism that prevailed there.

As against the gradual reduction in the German death rate it may be stated that "the prevailing general death rate of the United States (about 13.5 per 1,000) is the lowest on record and practically the lowest for any country of corresponding industrial activity throughout the world." What we are doing through voluntary, intelligent efforts on the part of the medical profession, in addition to the education of the masses in which is utilized "all the advancements in hygiene," gives promise of a further reduction of the death rate in the future.

That the physical preparedness of the German soldiery was due to her system of Compulsory Health Insurance is no more an invulnerable argument for that system than that these physically prepared soldiers were vulnerable when confronted by those of Uncle Sam who were products of the free, voluntary methods of non-compulsion.

The principle of coercion should not gain a foothold in this country where the results of free, voluntary labor have established it as the model among nations. As Dr. Hoffman well says, "Every unnecessary increase in government regulation, supervision and control is inimical to the fostering and the further development of the spirit of liberty in a true democracy." Incidentally, we may remark, that this is true of the inroads made upon the medical profession through the regulations of Rockefeller Foundations and National, State and City Boards of Health.

In the preparation of this paper I have relied mainly upon the writings of Frederick L. Hoffman, LL.D., for the statistics and facts mentioned. Dr. Hoffman is an authority upon the subject of health insurance, who spent two years in Germany and a year in England in the study of social insurance.

In a summing up of his examination, Dr. Hoffman says, "Compulsory health insurance did not improve the health of the working portion of the community nor did it materially raise the standard of public health. All the more conspicuous and gratifying results in the improvement of social conditions, the lowering of the death rate, the gradual elimination of preventable diseases, etc., were secured more effectively in

this country and entirely without compulsory insurance than in Germany or in the United Kingdom. Most of the social service institutions which have come into existence in Germany under social insurance have been established in this country in consequence of the aroused social consciousness, such, for illustration, as better hospitals, better infirmaries, better dispensaries, better safety-first rules and regulations, etc."

The annual report of the Communal Sick Fund of the City of Dresden for 1917 shows that the average duration of incapacity for work was 28 days for male and 33 days for female members. In 1884-5, when the fund was established the percentage of membership claiming sick benefits on account of absence from work was 30.4. In 1913, after 29 years of operation, the corresponding proportion was 32.2 per cent. The average duration of sickness was 23 days at the beginning as against 28.6 days in 1913.

"As evidence of failure to improve the social condition of the German people the statement is significant that of 4,021 persons injured during 1917 the proportion at the ages under 20 was 48 per cent. against only 15.9 per cent. for so representative an industrial establishment as the Scovil Manufacturing Company, of Waterbury, Conn."

In the annual report of the Communal Sick Fund of the City of Hanover under maternity care, it is stated that out of 1,294 pregnant women 221, or 17.1 per cent., were mothers of illegitimate children. The corresponding proportion for the Lying-in-Hospital in the City of New York is 0.4 per cent.

In Berlin the suicide rate has increased from 2.3 per 1,000 in 1900 to 3.8 in 1913, while that of Manhattan and Bronx has decreased in the same period from 2.4 per 10,000 to 1.8.

If we pass to England where Compulsory Health Insurance was hurriedly pushed through the House of Commons by Lloyd George in 1911 we find a repetition of failure to achieve its ends.

To again quote Dr. Hoffman, "After seven years of experience the viewpoint of leading manufacturers and other employers of labor throughout Great Britain is that national health insurance has no direct relation whatever to labor efficiency except that a large amount of malingering tends persistently toward a diminution of normal output. There is much unnecessary absence from work on account of minor ail-

ments, etc., prolonged into alleged sickness of six days' duration or more to secure cash benefits which would otherwise not be payable."

To be forced to continuously pay contributions for any object leads to a desire to obtain some return for these payments. This is true of compulsory insurance, and it has been found "by the experience of medical referees that the proportion of cases investigated and found fully able to return to work is rarely less than 40 per cent. and often exceeds 50 per cent."

Employers lose much through malingering and workingmen lose much more in character through the lying and deceit which they employ in securing these ends. There is also an additional loss in time to both parties through the number of calls for the purpose of correcting cards, effecting transfers, paying arrears or receiving benefits. In Germany a fund of 40,000 members will have on an average not less than 1,000 callers a day at the central office.

It is utterly impossible in a short paper such as this to even mention the points collated by Dr. Hoffman showing the utter failure of National Health Insurance. Its inefficiency in England is constantly a source of discontent among the insured; its inadequacy to furnish the necessary treatment except for minor ailments, its complex character of administration; its proven tendency to lessen the old friendly society spirit among workingmen and in other ways to diminish their general trustworthiness; its tendency to undermine established principles of government by supplanting them with pure socialism; its real nature—not insurance, but rather a system of taxation; its condemnation "by labor leaders as contrary to the best interests of the labor element and by large employers of labor as a menace to productive industry; by public health authorities as of no value in the furtherance of public health measures; by authorities in charity, philanthropy and those who administer poor relief as not rendering satisfactory aid and assistance to those most urgently in need thereof, and by the organized medical profession as opposed to the best interests alike of panel practitioners and those who limit themselves to private practice."

We will confine our remaining space to some remarks upon the effects of the National Health Insurance measures upon the medical profession.



If, as it has been shown, social insurance is a failure in both Germany and England in its benefits to the working-man, its effects upon the medical profession have been absolutely pernicious.

In England the panel physician is allowed 7 shillings 6 d. per annum for each person insured, but this is dependent upon the amount available for distribution. The physician frequently has to wait a long time for his money. In 1918 they received only 81 per cent. of the bills rendered. No matter what a patient may require the physician is limited in his prescription to comparatively inexpensive items. "All thought of supplying only the best drugs went to the wind." As about 1 shilling 6 pence is allowed for this purpose the physician's time is taken up in calculations to prevent exceeding this amount, and meetings of medical societies have been devoted to labored calculations upon the part of the members to keep their reports within the limits. Thus the scientific character of these meetings has been neglected for mere clerical labor. In order that a panel practice may pay a sufficient amount the physician sacrifices quality of service for quantity in patients. The average time devoted to diagnosing a case has been found to be five minutes. All patients are urged to come to the physician's office and he discourages house calls. In short, his work is reduced to a sort of official drudgery. He has no time for studying the patient's case, no time for proper diagnosis either of the disease or the remedy. His time is taken up with an elaborate system of reports of more or less complexity, a kind of labor that is repulsive to one of scientific mind or of independent investigation. Why should this system, a product of German Socialism, which has failed after 25 years' trial in Germany and 9 years in England, be fastened upon the medical profession of the United States?

Its tendency is to stifle individual effort in scientific research, to reduce the medical profession from that of a noble calling to a mere trade or department of the State; to discourage the best youth of the land from entering upon the study of medicine; in short, compulsory health insurance is sufficiently pernicious in its effects to gradually undermine the medical profession and prove to be the entering wedge of Socialism that will ultimately destroy all the free and independent efforts which are characteristic of our democracy.

In these troublous times with the insidious as well as

active attempts to force Socialism upon the world, if we would perpetuate the blessings that have been enjoyed under our democracy we must emphasize the doctrine of individual rights and hold back for rare application the opposite (and socialistic) doctrine of the sacrifice of individual rights for the benefit of the mass.

The best State is composed of the best individuals and individuals differ mentally, morally and physically. They find their best development not under compulsion but in the free, voluntary expression of their rights, and the best State is made of such a people.

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## COMPULSORY HEALTH INSURANCE.

BY

ELWOOD S. SNYDER, M.D., LANCASTER, PA.

(Read before the Homœopathic Medical Society of Central Pennsylvania.)

VOLUNTARY HEALTH INSURANCE, unlike life insurance, is of comparatively recent development. It is, therefore, expected that health insurance will show a growth and tendency toward standardization, as the importance of such insurance is more generally recognized. Certain of the methods by which the sickness hazard is insured against, during the short period of their use, have extended with a wonderful rapidity; this goes to show that public recognition is given more liberally than it was assumed, and the importance of health insurance is, therefore, growing rapidly. The main difficulty at present is the unwillingness of wage-earners to insure, because of the lack of appreciation of the relative importance of insurance and other things. Few could not pay for insurance, if they desired to do so. Society does not consider making it a legal requirement that the individual shall each pay-day save a portion of his earnings to provide against the almost certainty of unemployment or that he shall have life insurance to provide against the certainty of death. Not until the individual threatens society in a direct and immediate way is it considered a sound policy to compel the action of the individual.

Compulsion by law has frequently resulted in conduct

beneficial to the individual when considered solely as a physical betterment. But guardianship by Government of the normal adult, man or woman, has, sooner or later, ended in disaster for the Government, which attempted it, or in the servility of those so governed; therefore, unless society is affected in an important way, the conduct of the individual should be determined by his own understanding, and not by the law or Government. Therefore, we, as a profession, are not justified in any way to recommend compulsory health insurance.

It is a well known fact that causation or responsibility for disease cannot be rationally assigned on the basis of a classification of diseases, with the exception only of diseases to which workers in an occupation are exposed, and which are not found in those not engaged in that occupation.

Compulsory health insurance was introduced in Germany in 1883, by Bismarck, at that time Chancellor of Germany, and was the second step in an elaborate scheme of paternal socialism.

It was introduced in England in 1911, and now an attempt is being made to introduce it in America. Social Reformers, Welfare Workers, and the American Association of Labor Legislation have evolved this theoretic plan of social betterment, predicated solely upon conditions and social systems existent in Europe before the world war. They plan, also, unemployment insurance and old age and death insurance by State provision—thus you see the never-ending and unlimited deluge that is possible of agitation and all to the further imposition upon our State funds. That these so-called Social Reformers, Welfare Workers and the American Association of Labor Legislation, and the Federation of Labor have already obtained listening ears is shown by the fact that commissions have been appointed in eight States. Favorable reports were made in Ohio, New York, Massachusetts and California. Unfavorable reports were made in Illinois, Wisconsin and Connecticut. In our own State of Pennsylvania, a commission asked to be continued, showing the influence of pressure brought to bear. In Massachusetts a second commission brought in an unfavorable report. In California, November, 1918, an amendment proposed to the Constitution, providing for compulsory health insurance was defeated by a vote of 358,324 to 133,858. A model bill was introduced in the New



York Legislature in 1919, and was defeated by two votes only. The same bill was again introduced in 1920 and withdrawn because of great pressure and another possible defeat.

The plan of Compulsory Health Insurance as proposed assumes that all regularly employed individuals, men and women, earning less than \$1,600 per annum, and for the dependents, the plan compels provision by the Government by law, the following benefits:

1. Medical service.
2. Surgical service.
3. Nursing service.
4. Hospital service.
5. Maternity service.
6. Dental service.
7. Drugs and dressings.
8. Funeral benefits.
9. Cash benefits (26 weeks in any one year).

Now, beneficiaries and their dependents will approximate 4,000,000 individuals in Pennsylvania. Thus, you see, by calculation, the cost in our State would approximate annually \$65,000,000. The plan calls for State supervision and local administration, and compels the cost to be provided and divided fifty-fifty by employer and employee. The plan calls for State supervision and local administration for less than \$20 per capita per annum, to pay management of the funds set apart and the nine items of service to each employee and his dependents. The plan becomes a menace to public health and medical service, because the medical care of a given panel, group or local fund will be awarded to the physician contracting to give such attention for the least yearly amount of money. The number insured may be 750 to 1,000. With dependents, the individuals under one panel physician's care may total 1,850 to 2,500. Two thousand such associations in Pennsylvania will mean 2,000 lodge practice physicians, and 8,000 full pay or part pay log-rolling political jobs.

This is the most radical scheme for social legislation yet presented in this country. The first step is called "Workmen's Compensation," which, in reality, is compulsion applied to the employer for the benefit of the employee, the cost of same being applied to the employer for the benefit of the employee. The same is now passed by the industry involved to the consumer. It is a long step, however, from compensation for an

injury received directly in the line of industrial duty, to compelling the employer to pay 50 per cent. of all expenses involved in the treatment of "measles," for instance, developing among the dependent children of his employees. The direct result of this type of legislation is paternalism on the part of the State, with consequent death of individualism among its citizens.

Our federation of States is founded as a protest against discriminating laws and was originally composed of thirteen Colonies representing many individual ideas. How well these ideas are developed is now an epoch of history. Since 1914, however, government of the people, by the people and for the people has been on the descendency and may perish from the earth. That such calamity may not come to pass, let every American, who by birth or association, possesses the traditions of his country, voice now and always, these lofty sentiments of the great Abraham Lincoln. Let us discourage interference in personal and industrial development, and discountenance a system of morals or law which justifies an individual in looking to the community rather than to himself in sickness or age.

The employer should oppose because most sickness is traceable to ignorance of or the wilful violation of well recognized laws of health or hygiene on the part of the individual employee or his dependents. He is not responsible for the illness developing among his employees and their dependents, nor does he benefit from the same against the losses occasioned thereby, and he should not be forced to contribute to such relief. Only true occupational diseases should be fully compensated by the industry involved.

To the employer, the compulsory feature of the scheme diminishes independence of spirit, and promotes class-making features, dividing workers into classes—those who are forced to insure and those considered capable of caring for themselves. These features are un-American. Adequate wages and better working conditions, without forced insurance, contributions by employers without any appearance of charity, and permits advantage of privately managed voluntary forms of insurance with free choice of any doctor or dentist, etc.; furthermore, any inability to measure up to physical requirements of insurance proposed by any such legislation act may result in loss of employment.

The taxpayer already supports financially all well established State agencies for prevention and control of contagious diseases, *i. e.*, dispensaries, sanitariums for tuberculosis and venereal diseases, treatment through dispensaries and hospitals of dependent sick individuals and the complete care of the indigent, disabled and insane.

State supervision of workmen's compensation insurance costs the taxpayers of Pennsylvania annually several hundred thousands of dollars; State supervision of health insurance covering the insured regular employees plus their millions of dependents, will cost the taxpayer considerably more than does workmen's compensation insurance. The taxpayer will find, if he is an employer, his total contribution of 50 per cent., pro-rated to him, considerably more than the workmen's compensation.

It is estimated that 20 per cent. of the beneficiaries will each year collect cash benefits from the funds, with the history of malingering under other plans of insurance, and the existing lack of confidence in the successful management of politically-controlled "locals" or "panels," in the disbursement of many millions of dollars to hundreds of thousands of individuals throughout the State.

Will compulsory health insurance fairly and efficiently distribute the cost over large groups of individuals? If not, then its proponents have not a leg to stand on. Such propagandists like to speak in the same breath of compulsory health insurance, fire insurance and life insurance. The economic and social value of fire and life insurance is obvious and the Illinois commission found 77 per cent. of male heads of wage-earning families throughout the State protected by an average of \$850 per man. Ninety per cent. of insurable risks are protected by fire insurance in Illinois and Ohio, but 3 1/3 per cent. of the costs of sickness are covered by insurance. Why this startling contrast? There are two reasons: Excessive cost and excessive waste. Three thousand dollars of fire insurance costs annually \$5. If it cost \$750 annually, few would carry the protection, yet \$5 and \$750 represent approximately the difference between the cost of fire insurance and sickness insurance. The family type of insurance will reduce the average protection to \$1 for each \$1 premium.

The United States Bureau of Labor Statistics ascertained that in 1918, in Cleveland, Toledo, Loraine and Columbus, 719



families had sickness expenses averaging \$42 per family. Ninety-nine per cent. of the families had sickness, seven families of the 719 had sickness expenses amounting to \$300. Here you see the 99 per cent. would be insured to protect the very unfortunate 1 per cent.

From July, 1914, to December, 1918, it cost the fourteen largest self-insuring groups in New York State \$2,178,000 to distribute \$5,353,000 in benefits. This equals 41½ per cent. to distribute every dollar in benefits under the workmen's compensation act. It also cost the State of New York 4½ per cent. to supervise the spending of each dollar; hence, a total of 46 cents to distribute each dollar of benefits. These costs being paid by business firms spending their own money for specific injuries received, now to what proportions will they mount under a politically-controlled system of compulsory health insurance, planned to cover common colds, measles and all minor ailments among employees and their children?

In closing, therefore, I would direct you to at least ten good reasons why physicians oppose the proposed plans of compulsory health insurance:

1. Class-creating features are un-American. This is bound to be as shown above.

2. The enormous cost in money will be out of all proportions to the principal benefits, as shown above.

3. Where tried, the plan has not favorably influenced sickness nor reduced the death rate. (Austria and Russia show 100 per cent. increase, instead, in mortality among the sick.)

4. Where tried, the plan has resulted in such widespread malingering that bureaus of investigation were created to combat same.

5. In Germany and England, health insurance has demoralized the medical profession by removal of incentive to individual advancement and has stunted research work.

6. The plan established means creation of thousands of small political jobs, and creation of a State Bureau of Laymen in control of treatment of sickness.

7. While it may be prevented by wholesome methods, its successful treatment is entirely a question of confidential individual and personal relation between physician and patient.

8. Social conditions in the two continents have been diametric opposites, and true Americanism is centered only in

the defeat of all efforts to introduce European State socialism into the United States.

9. The compulsive features are distasteful to employer, employee, physician and beneficiary alike—compulsion to pay premiums, compulsion to attend certain patients, also compulsion to accept attention of certain physicians.

10. All plans proposed to date will result in the evils of contract medical function in its most malignant form, *i. e.*, lodge practice raised to the degree maximum of demands by beneficiary and minimum service by physician.

Now, ten devices approved by physicians that will in orderly process reduce to the minimum the incidence of sickness and equitably ameliorate its economic losses:

1. Enforced observance of all existing laws of health, hygiene and housing.

2. Educational campaigns along preventive lines, originated by State Health Department and disseminated through approved channels, including medical organization.

3. Development of plans for prenatal care and infant hygiene to the period covered by existing school laws.

4. Intensive development of existing provisions for State, county and municipal functions in preventive and remedial medicine.

5. Amplifying the scope of institutional clinical facilities for diagnosis and treatment, whereby all physicians and their patients may have access to the most modern methods.

6. Determination of industrial's responsibility and full assumption of same through industrial medicine in all true occupational diseases.

7. Increased facilities for State aid to the victims of prolonged, disabling sickness, the only type actually concerned in the production of poverty.

8. More thorough State supervision of existing sickness insurance funds, in order that more individuals may in self-respecting manner provide for the periods of sickness common to all or most of us.

9. Elimination of existing plans and future avoidance of administration of charity, whereby the members of the medical profession are the only unremunerated agents.

10. Public co-operation with our progressive scientific development of State medicine and management of the true charity problem.

May I not say, gentlemen of the profession, to these things we should aspire, yes—have, hold and maintain them.

## EDITORIAL

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### THE RECENT ATTITUDE TOWARD THE GALL-BLADDER.

RECENT work of Lyon is of great interest and if as practical as it apparently seems, is a great step forward in preventive medicine. Lyon, following the work of Meltzer, has succeeded in making use of a physiologic fact as a means to diagnose and treat diseases of the gall-bladder. Meltzer (1) applies to the gall-bladder the law of "contrary innervation." The facts confirmed by him are that peptones and certain other substances, when they reach the duodenum, cause a relaxation of the sphincter at the duodenal end of the bile passages and coincidentally a contraction of the gall-bladder. The gall-bladder, besides acting as a reservoir for bile, concentrates that medium and discharges it in that form so that it can more efficiently play its role during digestion. The relaxation of the sphincter of the common duct and contraction of the gall-bladder are controlled by the same mechanism as contracts the sphincter and relaxes the bladder to allow the storing up of bile for future use. Disturbances of this law are important factors in the pathogenesis of many disorders of the biliary passages.

Gall-bladder infections, besides resulting from the invasion of bacteria carried via the arterial, portal or lymphatic circulation, result from bacteria ascending from the duodenum. To accomplish infection there must be stasis, which usually results from a fasting state, as in typhoid fever, or from a catarrhal inflammation secondary to a gastro-duodenal catarrh (5). That gall-bladder disease and gastric atony are associated can be surmised by a consideration of the recent findings of Fravel (6), who demonstrated that with gall-bladder disease a hypochlorhydria is by far more common than is a hyperchlorhydria.

Lyon (2) by instilling magnesium sulphate solution of various strengths directly into the duodenum, succeeds in producing an evacuation of bile in a short time. The result is brought about by the relaxation of the sphincter of the common duct and the contraction of the gall-bladder. The oral administration of magnesium sulphate produces no such reaction. Whether the salt acts as a chemical messenger or



hormone is difficult to determine. The action may be one of selective affinity for the nerve endings which control the functions of the gall-bladder and common duct. In this connection it is interesting to note that Edkin (3) found that decoctions of the pyloric mucous membrane, when injected intravenously, would stimulate the flow of gastric juice. Would extracts of the mucosae of duodenum or bile passages cause the drainage of bile, if injected intravenously?

By means of the duodenal tube and magnesium sulphate, Lyon finds that one can withdraw and distinguish duodenal contents, bile from the common duct, bile from the gall-bladder and bile from the hepatic duct in the order named. By means of a glass window in the tube, these four substances can be conveniently collected into separate containers and subjected to chemical, cytological and bacteriological examinations, for the differentiation of cholecystitis, cholelithiasis and choledochitis. When cholelithiasis exists the addition of acid gastric contents to the bile, creates an effervescence and Lyon (7) suggests that hydrochloric acid be added to specimens of bile withdrawn and any turbidity resulting, studied.

In patients in whom the gall-bladder has been removed there is a continuous flow of bile, because of the disturbed nervous mechanism. While the common duct may act as a reservoir and an intermittent biliary flow result, the make-shift soon fails, partly because the bile is not properly concentrated (8). Mann (9) found in experimenting with animals both with and without gall-bladders, that the tone of the sphincter of the common bile duct varies considerably. In species possessing a gall-bladder, the sphincter was able to withstand much more pressure than that in species without a gall-bladder. In the latter instances the sphincter, while present, did not seem to functionate appreciably.

Barker (4) sees in Lyon's method a valuable therapeutic measure. Not only can the location of diseases of the biliary passages be determined; but by the evacuation and drainage of bile, the patient can be benefited. To date the attitude toward the gall-bladder has been one of, "Correction of full-blown stages of formed calculi and active catarrhal infection." (7). Since drainage prevents stasis, it may be a logical procedure in suspected cases, because stasis causes an overdistention and atony of the gall-bladder, which atony in turn engenders a catarrhal inflammation and weakened resistance which may result in infection and calculi.

From our foregoing remarks upon the physiology of the gall-bladder, it will be noted that frequent meals, to get peptone into the duodenum, are necessary for a flow of bile; while fasting inhibits the flow and tends thereby to produce stasis. The common finding of typhoid bacilli in the gall-bladder after typhoid fever and the consensus that typhoid infection predisposes to gall bladder disease, should stimulate us toward making the starvation treatment of typhoid fever even more obsolete. After all illnesses in which biliary stasis may result because of a greatly restricted diet and particularly after recovery from acute infections, it would seem not amiss to drain the gallbladder by the method adopted by Lyon (2) to prevent future trouble. This could be practiced as conveniently as the use of enemas to aid elimination and would perhaps be of far greater benefit, not only to the patient, but to the world at large, because it may prevent such menaces as typhoid carriers.

J. G. W.

#### REFERENCES

- 1.—Meltzer, S. J., *Amer. Jour. Med. Sc.*, 1917, 153, 469.
- 2.—Lyon, B. B. Vincent, *Jour. Amer. Med. Asso.*, 1919, 73, 981.
- 3.—Edkin, *Jour. Physiol.*, 1906, 34, 133.
- 4.—Barker, L. F., *Jour. Amer. Med. Asso.*, 1920, 75, 1105.
- 5.—Lyon, B. B. Vincent, *Amer. Jour. Med. Sc.*, 1920, 159, 503.
- 6.—Fravel, R. C., *Amer. Jour. Med. Sc.*, 1920, 159, 512.
- 7.—Lyon, B. B. Vincent, *Amer. Jour. Med. Sc.*, 1920, 160, 515.
- 8.—Lyon, B. B. Vincent, *Med. Clin. North America*, 1920, 3, 1253.
- 9.—Mann, F. C., *Jour. Lab. and Clin. Med.*, 1919, 5, 107.

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#### FEDERATION.

WITH the announced intention of the Homœopathic Medical Society of Pennsylvania to enter the Federation as proposed by the American Institute of Homœopathy, virtually all State Societies have come in to the Central Organization. Our opinions, as well as those of a large number of constituents on this subject, have already been announced in our various editorials. The important objection that we have to it lies in the fact that all details so far announced from central quarters have been of a most indefinite character, and give to the outsider no conception of what is really to be effected, beyond the fact that every one knows good organi-

zation is necessary to success. At sessions of the Congress of States already held, proceedings have been apparently without purpose, consisting of addresses of literary merit and worthy of thought, it is true, but nevertheless not of a character to get us anywhere, as they have neither proposed nor suggested action. The result is that in certain quarters where enthusiasm existed at one time, lukewarmness now prevails.

We repeat that we believe in federation, and while our ideas may not appeal to everyone, we at least have ideas, and, as it appears necessary for some one to start something, to get somewhere, we have no hesitation in expressing our views, as follows:

First, we believe that the Congress of States should take over the whole matter of business of the Institute, even unto the election of officers. Business is as much a specialty as disease of the ear, eye or other organs of the body, and will be handled more efficiently by specialists. It is, therefore, likely that the Institute business will be more wisely conducted if left to such specialists.

Secondly, we believe that delegates appointed to the Congress of States should be chosen carefully by the constituent States with due regard to the certainty of attendance and ability as to business and parliamentary judgment.

Thirdly, we believe that the Institute should limit its own proceedings entirely to scientific papers and discussions thereon. Heretofore, business has taken the right of way early in the morning and by reason of lack of system, or the desire of too many to speak on a subject, business has encroached on the scientific program to such an extent as to become tiresome to members. The neglect of scientific matters by the Institute has caused certain classes of our physicians to form their own separate societies within the Institute and under the Institute, but not to be interfered with by the business affairs of the Institute.

Fourthly, we believe that no physician should be elected to the Institute until he has become a member of his own State Society. It is the duty of the Institute to encourage prosperity of the State and County societies which should be regulated by the tributary bodies. One year ago there were in Ohio 60 physicians members of the Institute not members of their State Society. At the same period, there were in Pennsylvania, 100 physicians, members of the Institute, not



members of the State Society. These figures have been materially reduced, but that they existed at the time specified is evidence that there was something wrong, something that should not exist.

Fifthly, we believe that the proposed method of electing members must mean a better ethical and scientific standard for the Institute body, for no man's qualifications are known better than by his neighbors. He can make a big display abroad for two or three days each year, but he can scarcely conceal his shortcomings or delinquencies from his neighbors for the year round.

Sixthly, we believe in the necessity of a permanent and trained body of delegates from various States, selected by their constituents. Such a body, knowing its importance, will not treat the office of delegate to the Institute frivolously, but will surely make it their paramount duty to be present and to do good conscientious work. The delegate system depends entirely upon the character of the delegates selected. It is the best system we have if the selections are good—if the selections are bad, the less we say of it, the better.

We submit these ideas to our readers. We trust they will receive careful consideration. They may be valueless, but at any rate they have the merit of saying something which must either bring approval or opposition or amendment. The sooner these matters are considered seriously, the better for our parent body.

Government by a strong well organized central association is always a good thing, but it can be overdone. It is possible for an organization to be built up to such an extent as to cause it ultimately to fall by reason of its own weight. In other words, too much government is as bad as too little. It is the wise association that knows its limitations. Too much power tends to disorientation of action.

Today the American Medical Association is the great power of organized medicine in the United States. Its prestige has become so great in this respect that individual State and subordinate societies have lost the influence that the individual strength of their component members should give to them. Mark today the would-be great medical societies of the country, and note how little is the part they play in the medical body, politic and scientific. Badly balanced power is not a good thing.

1920—1921.

THE Editorial Committee, in closing their work for 1920, take this opportunity of thanking their many new friends who have contributed to the present prosperity of the Journal. Unless something unforeseen happens they will ere long be able to produce a "pre-war size at pre-war prices." To hasten this much-desired event, the assistance of all the subscribers is solicited. They are asked to spread abroad their opinions of the Journal.

In 1921 the Committee will endeavor to do better by reason of increased experience and by the encouragement thus far given them. At the present writing an important announcement may be made. The January issue will be the most enterprising number of any monthly medical journal of our school. In addition to the regular material, it will contain a full report of all the clinics held at Hahnemann Hospital of Philadelphia on National Homœopathic Clinic Day. It is estimated that this added material will make over 100 pages. This will be the first time in the history of our school that a systematic report of a series of clinics has been published.

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#### THE INSTITUTE JOURNAL: DR. C. E. FISHER.

It will be pleasant news to all of our older practitioners who are well acquainted with homœopathic literature to learn that the Trustees of the American Institute of Homœopathy, at a meeting held in Richmond, Va., on November 18th, elected Dr. Charles E. Fisher to the editorship of the Journal of our national organization. It is not too much to say that in so doing they could not have made a wiser selection. Dr. Fisher is no neophyte in editorial work; and he is by no means an amateur in organization. He has a brain that works on system and is most decidedly an independent thinker of ability. His original sphere of professional activities was in Texas, where he built up a large practice, and becoming interested in the welfare of organized homœopathy, founded the Southern Journal of Homœopathy and took an active part in the affairs of the Southern Homœopathic Medical Association. Later he removed to Chicago, where he found a larger sphere

for his talents, and founded the *Medical Century*, which had a large circulation for a number of years, when he retired from journalistic work, Dr. W. A. Dewey, of Ann Arbor, taking up the editorial work. This short review of Dr. Fisher's career is evidence of the wisdom of our Board of Trustees. We have no hesitation in endorsing Dr. Fisher as a worthy successor of Dr. Sarah M. Hobson, the recent editor of the *Journal*.

Dr. Hobson's entrance into and retirement from journalism were both characterized by the personality and the modesty of the individual. On both occasions there was no flourish but merely an entrance and a departure, the intervals between which were occupied in faithful and efficient work. For a number of years, this work was performed under trying conditions and at a personal sacrifice, and it was not until the demands of private practice absolutely forced a retirement that she laid down the editorial pen in June last.

The readers of the *Journal* have missed her guiding mind, and the Trustees have done their best pending the selection of a successor.

In so doing they have not acted precipitously but with due care and fine judgment. We praise the Trustees; we rejoice with Dr. Hobson; we congratulate the Institute and its *Journal*; and we extend sympathy and good wishes to Dr. Fisher.

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#### THE AMERICAN INSTITUTE OF HOMŒOPATHY AND ITS FINANCES.

WE have been hearing of late quite considerable concerning the necessity of the American Institute of Homœopathy for more money than has hitherto been available. Much of this talk on the subject tends to give the hearer the idea that we are in financial danger, whereas the time has arrived when our National Society is obliged to become one of big business or lose its utility; and big business needs an abundance of capital.

Now let us state the question plainly as follows: The American Institute of Homœopathy needs money and needs it legitimately for extension of legitimate business. It needs that increased income now, and it will need it for many years to come. Perhaps it will need it forever, if it takes on the duties its position in the medical world demands of it.



There is only one way to solve the problem, and that is endowment. The principal required need not be great if quick action is taken at a time when good investment securities can be purchased at a price that will bring in a high interest return. In other words, two dollars now will probably be found to be worth four dollars a year hence. With four thousand members, the demands upon each member need not be great. Inasmuch as the permanent maintenance of the Institute is of greater interest to the laity, the bulk of the fund should come from that source. It is a fair statement to make that the influence of our physicians is such that the average of their ability as "raisers of funds" should be \$100.00 each. Doctors should not be expected to make heavy contributions to the fund as a class, as the peculiar social and economic conditions by which they are surrounded makes it impossible for them to possess any cash surplus to warrant such outlay.

Special assessments and increased dues are not popular and endanger the welfare of any society, and should be carried only when positive necessity demands it, and when there is an assurance that the proposed measure is but temporary only. **ENDOWMENT IS THE THING** to make the Institute finances permanently healthy.

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#### **COMPULSORY HEALTH INSURANCE.**

THE national importance of this subject has caused the editorial committee to devote this entire issue to its thorough consideration. Hereafter communications on Health Insurance will be declined. The subject may not appeal just now to physicians outside of Pennsylvania, as the present fight is entirely within our borders. The first skirmish took place in New York State and was won by the physicians. The one now on in Pennsylvania is attracting nation-wide attention, and on the result will depend how far the misguided movement will spread. Hence legislative committees in every State of the Union must be watchful.

Should a Health Insurance Bill be introduced at Harrisburg, we enjoin upon all physicians in the State to arrange their affairs so as to be present in person when the bill is called and when the Legislative Conference gives them notice. Such a protest will mean something. There are 11,000 physicians in Pennsylvania. Let 6,000 of them take a day off for protection of family and home.

## GLEANINGS

### MEDICINE

Conducted by CLARENCE BARTLETT, M. D.

APHORISMS CONCERNING THE DIAGNOSIS AND TREATMENT OF DUODENAL ULCER.—Dr. John Dudley Dunham of Columbus, Ohio, in an article entitled, "Errors in the Diagnosis and Treatment of Duodenal Ulcer," makes the following statements, which may well be classed as Aphorisms:

"A diagnosis of duodenal ulcer should never be made without a thorough general examination. One requires chemical tests of the chyme, stools, urine, a blood count, a Wassermann test and, most important of all, fluoroscopy of the chest and abdomen. Lavage eight hours after a Riegel meal is also important, indicating at times a gastric stasis not shown with barium. No one of the above measures will prove the existence of duodenal ulcer, but all will aid in the differentiation of other diseases with similar histories."

Hemorrhage is a late complication and proves neglect on the part of the clinician.

When we cease to recognize hyperchlorhydria and gastric neurosis as entities, we will overlook fewer early cases of duodenal ulcer.

Fluoroscopy of the chest will frequently disclose an enlarged aorta. This condition, with or without symptoms of an aortitis, is often present and suggests a syphilitic duodenal ulcer or visceral lues. Either of the latter diseases is easily confused with simple chronic duodenal ulcer.

Palpation for a tender spot should be made while the patient is in front of the screen. This is the only accurate means to associate the roentgen defect with the pain point. In fact, pressure over the tender area will often cause spasmodic contraction which may be seen in the greater curvature.

Diagnostic acumen will not be improved so long as we are content to say the patient has either duodenal ulcer, appendicitis, cholecystitis or visceral lues. In most instances, painstaking study will enable one to decide upon the correct diagnosis.

After making a diagnosis of duodenal ulcer, if one finds signs suggestive of syphilis the patient should be given the benefit of antiluetic treatment. This course is indicated even in the absence of a positive Wassermann test.

Internists, as a rule, will agree that the term "cure" following gastroenterostomy is a misnomer and should be considered "arrested cases. . . ."

Late recurrence of duodenal ulcer is more frequently observed by the internist than by the surgeon.

Errors in diet with the use of condiments and night pains, months or even years after the operation. A patient is with difficulty convinced that life-long attention to proper diet is necessary to prevent ulcer after gastroenterostomy. . . .

Rigid medical treatment in a hospital should be employed before a surgical operation is undertaken. I am firmly convinced that hap-hazard medical treatment is responsible for many failures. . . .

The duodenal tube is a foreign body near the seat of ulceration and should not be employed. It is, furthermore, usually a source of annoyance to the patient.

Alkaline drugs are well known as stimuli to gastric secretion at an interval after their ingestion, and should be omitted."—*American Journal of the Medical Sciences*, November 1920.

EMETINE IN THE TREATMENT OF HÆMOPTYSIS.—According to Colbert and Bazin (*Bull. et Mem. Sec. Med. des Hop. de Paris*, May 13, 1920), the differences in opinion as to the value of emetine in tuberculous hæmoptysis are due to the fact that the drug is only active in cases of hypertension, and occasionally in cases of low tension where the hæmoptysis is accompanied by a rise of blood pressure. Waller's experiments have shown that the most favorable conditions for hæmostasis consist in arterial vaso-constriction, with diminution of the energy of the heart-beat. The writers found that emetine acts on the maximum and the minimum arterial pressure, and on the oscillographic index. The treatment consists in giving an intramuscular injection of 0.04 gram of emetine, which is repeated once or twice in the day. As soon as the blood pressure falls the dose is reduced, but the drug should not be discontinued too soon. Administration of emetine should be associated with purgation by sodium sulphate and the restriction of the diet. Adrenalin and horse serum should be avoided, as they often raise the blood pressure. If the temperature is too high, small doses of antipyrin should be ordered, as this drug has also a hypotensive action.—*The British Medical Journal*, October 16, 1920.

PRIMARY SYPHILITIC JAUNDICE.—Milian (*Paris Med.*, August 21, 1920), describes the occurrence in certain cases of a syphilitic jaundice contemporary with the chancre and appearing before the eruptive signs of the secondary stage. It is said to manifest itself a few days before or after the primary sore and is accompanied by little, if any, general disturbance of health; the liver is slightly enlarged and the urine reacts positively to Gmelin's and Hay's tests; fever, absent at first, appears at the same time as Wassermann's reaction becomes positive. Three illustrative cases are recorded in which the jaundice lasted twelve, twenty-two, and twenty-seven days respectively.—*British Medical Journal*, October 23, 1920.

THE NATURE AND TREATMENT OF TUBERCULOSIS HÆMOPTYSIS.—Rosenthal (*Ugeskrift for Læger*, July 29, 1920) has investigated the 157 cases of hæmoptysis treated at his hospital in the period 1908-1918. The course of the tuberculosis was benign in 132 cases, and rapidly progressive or erratic in 25. Classifying these cases according to the severity of the hemorrhage, he found that on the whole the proportion of benign cases was somewhat greater when the hæmoptysis was slight than when it was severe; but even when more than one litre of blood was lost 60 per cent. of these cases ran a benign course. In 77 cases there had been signs of exacerbation of the disease prior to the hæmoptysis. In 37 cases there had been one or several hæmoptyses a considerable time before admission to the hospital, yet they had not led to progress of the malady beyond a small limited area of benign disease. Among the 132 benign cases there were 46 which were consistently afebrile. The author concludes that exacerbations of the disease provoke hæmoptyses rather than vice versa. A comparison of the duration of the hæmoptysis in his cases with that of the hæmoptysis in Bang's cases, showed that the latter's advocacy of getting the patient up early is ill-advised. The author prefers immobilization with use of morphine and ice-bags.—*The British Medical Journal*, October 23, 1920.

GONORRHOEAL HEART DISEASE.—“According to Professor N. Jagic and Dr. O. Schiffner, of the Sophia Hospital of Vienna, affection of the heart is



generally regarded as a late complication of gonorrhoeal infection. Kolle and Hetsch estimate the frequency of gonorrhoea septicaemia at about 0.7 per cent. of all cases of gonorrhoea that come under treatment, but the heart is involved in only a small proportion of the septic cases. The best known and by far the most frequent form of gonorrhoeal heart disease is gonorrhoeal endocarditis, which, like endocarditis due to other causes, may be divided into verrucose and ulcerative. All writers are agreed that gonorrhoeal ulcerative endocarditis has a predilection for the aortic valves, which, according to Kulbs, are affected three and a half times as frequently as the mitral valves. The clinical symptoms are usually those of pyaemia, and the prognosis is thoroughly unfavorable. The verrucose form, of which Professor Jagic and Dr. Schiffner record an example, relatively frequently represents the only localization of gonorrhoeal infection. Its favorite situation is the mitral valve. In some instances complete recovery takes place, but in the majority of cases a valvular defect remains. Most writers are agreed that gonorrhoeal pericarditis is not infrequent, but according to Hofmann it hardly ever occurs alone, but is always found associated with other gonorrhoeal heart affections or inflammations of other serous membranes. Myocarditis of gonorrhoeal origin is less known, especially when it occurs in an isolated form, then either endocarditis or pericarditis. Professor Jagic and Dr. Schiffner record two cases, both of which occurred in the course of a generalised gonorrhoeal infection, but after the local affection had subsided. The symptoms were those of ordinary infective myocarditis, and dilation of the heart was found on physical and orthodiagraphic examination. As they had an opportunity of seeing these three cases of gonorrhoeal involvement of the heart within a relatively short time, the writers conclude that gonorrhoeal affections of the heart, especially mild forms of myocarditis, occur more frequently than is generally supposed, and suggest that some of the myocardial lesions of later life, for which there is no obvious cause, are of gonorrhoeal origin."—*The Lancet*, October 9, 1920.

THE DIETITIC TREATMENT OF DIABETES MELLITUS.—The technique pursued by different authorities in the dietitic treatment of diabetes is quite varied, although all of them base their technique upon the general principles that have hitherto been advocated by all physicians. Williamson's plan is quoted approvingly by Vaughan, and is as follows. "Williamson advises complete rest for a period of seven days. The patient need not remain in bed, but he should keep the prone position during this time. The only food permitted during the seven days is a mixture of casein, cream and water, given every two hours from 8 A. M. to 10 P. M. If casein is not obtainable in good quality the following prescription may be employed in its stead: Three eggs are beaten up with three ounces of cream in a little water. More water is added gradually until the mixture is four pints. Of this mixture the patient takes half a pint every two hours from 8 A. M. to 10 P. M. In addition he may take coffee or tea at 8 A. M. and 4 P. M. and a half pint of warm beef tea at noon, 6 P. M. and 10 P. M. No bread, no meat, and no other foods are permitted during this period. According to Williamson glycosuria promptly disappears in suitable cases under this diet, and at the end of the seven days a solid diet containing a calculated amount of carbohydrate is given. If sugar returns, as it may after a long period, the liquid diet is again instituted for a period of seven days. In some instances it has been found

more convenient to place the patient upon the liquid diet two days out of every week, while during the remaining five a small quantity of bread or other carbohydrate-containing food, as well as meat may be permitted. Williamson admits that this form of treatment fails in some cases and that it is without avail when there is marked acidosis. Most patients take the egg and cream diet for seven days quite satisfactorily. Some state that they feel remarkably well on it; others feel rather weak; only rarely do the patients complain of slight sickness, and in such cases, if casein has been employed, eggs should be substituted."—*The Journal of Laboratory and Clinical Medicine*, October 1920.

TREATMENT OF ULCER BASED ON EXPERIMENTAL DATA.—Rehfuß and Hawk have been making experiments with food upon students, and in all have studied 842 curves of acidity. Following various tests of diets, their observations demonstrated the remarkable ability of protein foods to produce increased HCL. secretion. While eggs, ice cream and vegetables and the cereals caused a minimum of the order named. They close their article by offering the following suggestions respecting treatment of gastric ulcer:

"1. There is unquestionably a form of ulceration in which there is no evidence of alterations in either secretion or motor function. The assumption, therefore, is that under these conditions the greatest attention must be paid to the subject of focal infections, the correction of toxemias (intestinal, etc.) and habits, particularly dietetic.

2. On the other hand, there are obviously a certain group of ulcer cases in which there are definite disturbances in function, particularly in the direction of vagotonia with its attendant hyperacidity, hypersecretion, and pylorospasm, and in alterations in motor function. The assumption is that these alterations are unquestionably the dominating links in the chain establishing the chronicity of ulcer. Therefore we are compelled to break its vicious circle, particularly through dietetic means.

3. Prolongation of the fasting period or the interdigestive period is undoubtedly the most favorable means of inducing gastric rest, and it is universally admitted that complete rest is most conducive to ulcer healing. This is accomplished by starvation and rectal feeding. The only cure which completes the starvation period is the one in which white of egg and butter are given following the starvation cure, and rectal feeding is kept up.

4. We have discontinued the use of nutritive enemata and substituted the Murphy drip by bowel with nutrient solutions. It is possible to introduce 1500 calories in this way far more effectively than by the enemata, and the treatment can be continued and discontinued at intervals with much less discomfort than is entailed in former methods.

5. Surgery aims at the drainage cure, and if this be the paramount point to be attained we can attempt to accomplish it dietetically by a diet which is simply composed of those substances which are rapidly evacuated by the stomach. Inasmuch as gastroenterostomy finds its greatest value in obstruction, so these methods of diet are indicated in just such cases. It is not true, however, that gastroenterostomy is uniformly followed by a reduction in acidity. These remarks do not pertain to excision of the ulcer.

6. If the question is the reduction of acidity unquestionably the diet should be preponderatingly carbohydrate, with emphasis laid upon cereals, vegetables, and bread. It is not true that the free acid is markedly reduced by the administration of meat. On the other hand, the free acid figures run

comparatively high after administration of meat."—*The Therapeutic Gazette*, October 15, 1920.

THE DIAGNOSIS OF SPINAL MENINGEAL TUMOR AND ITS PRACTICAL IMPORTANCE.—Doctor R. T. Williamson presents a study of the diagnosis of spinal meningeal tumor and emphasizes the following points:

1. Persistent localized root symptoms (girdle pain or pain in one limb), followed after a considerable time by paraplegia (of gradual or rapid onset), should always lead to a very careful consideration of the probability of spinal meningeal tumor, especially if the cord symptoms increase in "cross section" intensity, but do not ascend, or only ascend very slightly.

2. In certain rare cases the root symptoms (pains) may be absent, but in such cases the motor and sensory cord symptoms steadily increase in "cross section" intensity, but do not extend upwards.

3. Persistent abdominal or thoracic pain, if bilateral or of a girdle character, even if signs of paresis of the legs cannot be detected, should lead to a careful examination of the chest or abdomen for zones of diminished sensation (tested by cotton wool). If such be detected, and if they correspond to definite root areas, meningeal tumor should be carefully considered. Also brachial "neuritis" of very long duration should lead to a careful consideration of the possibility of spinal meningeal tumor.

Spinal meningeal tumor is a rare disease, but not so rare as is generally believed. Closer consideration of this affection in the differential diagnosis at the early period of chronic spinal diseases would lead more frequently to its early recognition and to early successful operation.—*British Medical Journal*, August 21, 1920.

OBSERVATIONS UPON VARIOUS TYPES OF DIABETICS UNDER THE PRESENT METHOD OF TREATMENT.—F. Gorham Brigham, from a study of a large number of diabetics over a period of ten years, draws the following conclusions: 1. That by all the modern methods of low calorie diet the diabetic patients do better than by former methods. 2. That without careful blood estimations, diabetics cannot be satisfactorily treated and good results obtained. 3. That the complications of diabetes will develop even though the urine contains no sugar if the blood figures remain high. 4. That the prevention of obesity will reduce the number of diabetics tremendously. 5. That the study of other functions, such as kidney function and the removal of all possible foci of infection, are essential to having the diabetic patient do well. 6. That the routine twenty-four urines must be more frequently done, or routinely done, to be able to recognize diabetes as well as other kidney conditions early, and allow earlier treatment. 7. That the disease diabetes illustrates the importance of laboratories where simple routine analyses can be done at a reasonable figure.—*Medical Record*, page 323, August 21, 1920.

ORCHITIS FROM MUMPS: THE NEED FOR CONSERVING THE TESTES BY INCISION OF THE TUNICA ALBUGINEA.—The studies of Ballenger and Elder show that mumps is followed by orchitis in from 10 to 25 per cent. of the cases, and in approximately one-half of the cases, atrophy of the testicle follows. The authors argue that the damage to the gland is done by the local toxic product of the mumps organism and by the pressure necrosis due to the inelastic tunica albuginea which prevents the testicular substances from swelling



in response to the inflammatory agent. The authors have proposed as a remedy, incision of the tunica albuginea. They have performed this operation now on three cases, all of which are now in good condition after periods ranging from twenty months to three years. Another factor in favor of the treatment is its logical foundation.

The following is the technic of the operation: The patient is anaesthetized with gas-oxygen. The scrotum is cleansed and painted with a weak solution of iodine. An incision is made in the anterior surface of the scrotum through the tunica vaginalis, and the testis is delivered. An H-shaped incision is then made through the tunica albuginea. The testicular pressure causes the swollen reddened substance to protrude somewhat through the incised tunica. If the swelling is extensive, other incisions may be made whenever indicated to relieve pressure. The testicle is then wrapped for a few minutes in a towel wet with a hot saline solution, and then replaced in the tunica vaginalis. A small Pensore cover is then inserted, and the incision closed layer by layer with interrupted sutures. A 25% ichthyol dressing is then applied and held in place by an ordinary suspensory.—*Journal of the American Medical Association*, November 6, 1920.

TYPES OF PNEUMOCOCCI FOUND IN THE THROATS OF 100 NORMAL PERSONS.—Meyer has studied the throats of 100 normal persons, none of whom had been exposed to contact with pneumonia patients. Pneumococci were found in 21 instances. Types I and II were not found in any case. Type IIA was isolated once. Type III occurred in 3 instances, and type IV in 17.—*Journal of the American Medical Association*, November 6, 1920.

## SURGERY

Conducted by J. D. ELLIOTT, M. D.

CHOLECYSTGASTROSTOMY.—White reports three operations of this type upon patients with persistent jaundice and obstruction of the common duct, in which the results were satisfactory. He believes that this operation has a place in surgery and his ideas of it are summed up as follows: 1. It is indicated in an irremediable obstruction of the common duct or division of the duct which cannot be successfully sutured. 2. For long continued drainage in infective biliary cirrhosis it is superior to cholecystostomy in that nutrition is maintained. 3. It is not a difficult operation, being easier and safer to perform than an anastomosis between the gall-bladder and the small or large intestine. 4. There is no danger of an ascending infection. 5. The presence of bile in the stomach, while unphysiological in a degree, is consistent with good digestion, and offers no argument against the operation. 6. The suture method of anastomosis is the only one to be employed.—*Surg., Gynec., and Obstetrics*. November, 1920.

DUODENAL DIVERTICULA, WITH REPORT OF A CASE.—Moore quotes the literature upon this condition and reports a case upon which he operated. The patient's symptoms had gradually increased in severity over a period of seven years, beginning with pain in the upper abdomen which came on soon after eating but now occurred about three hours afterward and was relieved by lying down but not from taking food. About a year after the onset he had an attack of bloody diarrhea with much mucus during which he suffered from a very severe abdominal pain, lasting twenty hours, but not accompanied by fever or vomiting.

The correct diagnosis was made by the x-rays and confirmed at operation when a diverticulum, 2.5 cm. by 3.8 cm., flattened out over the duodenum, was removed. It had a small pedicle and the opening was about 1 cm. in diameter. The stump was treated as in the case of an appendix stump but the duodenal lumen was so narrowed by this procedure that a gastro-enterostomy was performed. An old healed duodenal ulcer was found on the anterior wall close to the pylorus but this did not produce obstruction. All gastric symptoms disappeared and x-rays examination showed no abnormality other than a patent gastro-enterostomy.

**LATE RESULTS IN AUTOGENEOUS INTERNAL BONE SPLITTING.**—Thomas and Clark believe that not enough reports of the late results of series of bone-grafting operations have been published. They have selected 16 consecutive cases which they operated during the month of August, 1919 at the Army General Hospital No. 30, at Plattsburg, New York. In this series six patients had good permanent results and several more appeared to be doing nicely for periods up to two months, in whom non-union finally resulted. Three cases were infected, one of which was operated 3½ months after his original wound had healed and the others at 11 months after healing. Complete primary debridement was not so successful as when some of the fragments had been allowed to remain, for the callous between the fragments gave support to the graft. All fragments were attached to the periosteum, those which had been entirely loose having been cast off as sequestra. The best method of approaching the field of operation was by entering through healthy tissues and working toward the point of fracture. The intramedullary graft is best when it can be used, but with greatly attenuated bone it was found necessary to resort to a cortical graft. At a second operation in one case it was possible to observe the result of the first operation and it was found that the transplanted bone had united so firmly with the shaft as to give the appearance of one bone. Sepsis was the most frequent cause of failure, the next in frequency was slipping of the internal bone splint.—*Archives of Surgery*, November 1920.

**PERSISTENCE OF PYLORIC AND DUODENAL ULCERS, FOLLOWING SIMPLE SUTURE OF ACUTE PERFORATION.**—Lewisoohn has succeeded in following up seven of ten consecutive cases which were operated by him. Six of the seven had had an immediate gastro-enterostomy and a simple suture had been performed on the other patient. All had remained cured of all gastric symptoms except the last who still complains of pains and fullness in the epigastrium and occasional vomiting. He also reports in detail four cases treated by simple suture, who required a second operation and whose symptoms all disappeared after occlusion of the pylorus and gastro-enterostomy. His conclusions follow: 1. Immediate gastro-enterostomy in the treatment of perforated pyloric and duodenal ulcers does not increase the mortality. 2. Gastro-enterostomy and pyloric exclusion simplifies the post-operative treatment considerably. 3. Simple closure of the perforation will not cause a cure of the ulcer in a considerable number of cases. 4. Gastro-enterostomy will guarantee proper drainage of the stomach contents and overcome partial obstruction of the pylorus caused by post-operative adhesions. 5. Closure of the perforation, gastro-enterostomy, and pyloric exclusion should be the method of choice in the treatment of perforated pyloric and duodenal ulcers. Simple closure of the perforation should be reserved for only those patients

whose general condition is so poor that even a rapidly performed gastro-enterostomy would be too much of an operative risk.—*Annals of Surgery*, November 1920.

THE ORTHOPEDIC TREATMENT OF BURNS.—Harrigan and Boorstein call attention to the lack of care in treatment of burns in relation to deformities and, from their experience, are convinced that such deformities can be prevented by early application of orthopedic principles. They have taken much interest in this question and quote cases and show photographs to prove the efficacy of this treatment and the poor results when it is omitted. They have used only simple methods, such as tying the limbs in proper position, and have found no deformities, but, on the contrary, that healing has been accelerated. Early massage, exercises and braces aid in obtaining satisfactory positions and proper use of the limbs.—*Annals of Surgery*, November 1920.

THE SECOND GREAT TYPE OF CHRONIC ARTHRITIS.—Under this head Ely includes, Arthritis Deformans (German), osteo-arthritis (English), hypertrophic arthritis (Goldthwait), degenerative arthritis (Nichols and Richardson). He calls attention to the hypertrophic arthritis which is the most prominent feature of the roentgenogram and the bone atrophy which far exceeds the hypertrophy and is the characteristic lesion.

All cases of chronic arthritis fall into two classes, or types; those which do not show spurring at the lines of insertion of the capsule and lipping at the circumference of the articular cartilage and those which do show this spurring and lipping. The first type includes tuberculosis, gonorrhoeal, syphilitic, typhoid, diplostreptococcic joints, etc. The second includes the joints under discussion. Tabetic joints are not included.

Pathologically the gross changes are; cartilaginous and bony lipping at the circumference of the joint, with bony spurs at points of insertion of the capsule; thickening of the cartilage, then calcification and erosion, leaving the underlying bone bare; condensation of this bone (eburnation) with grooving in the line of joint motion; hypertrophy of the synovial membrane, with marked villous formation, and frequently fluid in the joint.

Adhesions between the bone ends never result from these changes, as they do in the first type of arthritis and the limitation of motion is caused by distortion of the ends of the bones. Spinal ankylosis forms an exception to this rule. Rarefaction deep in the bone with cyst formation and distinct, irregular cavities.

The changes in the cartilage are most prominent under the scope. The cells are swollen and in groups. It presents a tattered, irregular and often bizarre appearance. Later it disappears, leaving the bone bare. The marrow is often fatty and fibrous. It contains minute spicules of bone and cartilage, and the bone trabeculae close to the joint are increased in thickness. Rarefaction of the bone begins a short distance from the joint line, and is a constant and prominent feature.

The clinical material consisted of ninety patients who were seen during the last five years at the Stanford clinics. There were sixty-eight men and twenty-two women. The age varied from 28 to 76 years. Two were in the third decade of life, twelve in the fourth, twenty-six in the fifth, thirty-two in the sixth, fifteen in the seventh and three in the eighth. Almost two-thirds of the patients were between 40 and 60 years of age. Seventy out of seventy-four patients from whom a clear history could be obtained had



alveolar infection, which Ely thinks is the fundamental cause. Therefore his first step in the treatment is the extraction of infected roots and teeth.

He draws the following conclusions:

1. The great second type of arthritis has two distinguishing features; (a) bone production (lipping, spurring) at the joint line, and (b) absence (except in spinal involvement) of union between the ends of the bones, either fibrous or bony.

2. Its main pathologic feature is the presence of areas of aseptic necrosis in the bone near the articular surface. This is the primary change. The cartilage changes and the bone production are the result of it.

3. Its primary cause is probably infection in the alveolar processes of the jaws.

4. Infection in the jaws causes only this type of arthritis, never the first type.

5. The infections which cause the first type, namely, tuberculosis, syphilis, tonsillar and deep urethral infections, never cause this second type.

6. Mental emotion and disturbed digestion can only be considered as contributing causes, which change the secretions of the mouth, and make the infection in the jaws more active.

7. Trauma is effective only as straining a joint already mechanically damaged.

8. This is called the senile type of arthritis, merely because elderly people are prone to it. Alveolar infections are more common in the aged. It occurs occasionally in young people whose teeth and jaws are infected. —*Archives of Surgery*, July 1920.

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## UROLOGY

Conducted by Leon T. Ashcraft, M. D.

WHAT SHOULD WE DO WITH BLADDER TUMORS?—Kolischer advocates either fulguration or galvano-cauterization for benign tumors, followed by the use of radio-active substances. He feels that the tendency of papillomata to recur rapidly after excision by knife contra-indicates excision. If the papillomata is truly benign, fulguration is effective, but it is so difficult to determine whether it is benign, the use of the galvano-cautery followed by the application of radium is safer if there is any reason to suspect malignancy. The author is convinced that the radical excision of malignant bladder tumors has failed as shown by the fact that the primary mortality is high, the convalescence is tedious and painful, and the procedure is followed by early recurrence.—*Ill. Med. J.*, 1920, xxviii, 21.

RENAL CALCULUS WITH NEGATIVE X-RAY FINDINGS.—Hyman calls attention to the fact that a negative radiogram is not sufficient evidence of the absence of a calculus in any part of the genito-urinary tract. The lower the stone the greater the chance of its being missed roentgenographically. He claims that renal stones fail to show in from six to fifteen per cent. of the cases; ureteral stone, in from fifteen to thirty per cent.; and vesical stone in sixty per cent. In five of his own cases in which the X-Ray examination was negative, the stones were composed chiefly of ammonium urates. Three of these patients died following operation and autopsy revealed stones in both kidneys. The fourth passed a yellow stone five days after the examina-

tion; and the fifth recovered after the removal of a stone. The chemical composition of the stone is in many cases responsible for a negative X-Ray in the presence of stone, urates and uric acid being translucent to the X-Ray. Freyer also remarks that many stones not translucent to the Roentgen rays will not throw a shadow when they are surrounded by inflamed kidney, condensed fat, pus, or layers of fibrin. Hyman draws the following conclusions: That a negative X-Ray means nothing. Latent stones are frequent, such stones having urates as their main constituents. The passage of a ureteral catheter into the kidney pelvis does not prove the absence of ureteral calculus, in which cases, wax-tipped bougies will often demonstrate the presence of stone when other means fail. Conservation is the watchword in renal surgery, and a nephrectomy should be done only as a last resort—as the opposite kidney may be the seat of calcareous disease.—*Boston M. & S. J.*, 1920, clxxxiii, 74.

**REMOVAL OF URETERAL CALCULI WITHOUT OPERATION.**—Crowell and Thompson (*Southern Medical Journal*) report further observations on their method of removing ureteral calculi without operation as described by them originally in 1918. The method is as follows: A bismuth catheter is inserted into the ureter until it meets with obstruction. An X-Ray picture is taken to demonstrate definitely that the obstruction is stone, as well as to ascertain its size and location. Two c. c. of a 2 per cent solution of cocain is slowly injected into the ureter at the site of impaction. The ureteral spasm is so relaxed in a few moments that the catheter will usually pass beyond the stone where another c. c. or two of the anesthetic is injected to further deaden the sensation. At this point it is a good idea to distend the kidney pelvis with a physiological salt solution and inject sterile olive oil as the catheter is being removed. In this way the pressure above the stone is increased and assists in expelling it, while the muscular fibres of the ureter are relaxed and the sensation is deadened. If the eye of the catheter cannot be gotten above the stone, sterile olive oil is injected against it with considerable force in effort to dislodge it as well as to lubricate the parts and dilate the ureter below the obstruction. The patient is given morphia and instructed to drink water freely. This technic is repeated every second or third day, increasing the size of the ureteral catheter each treatment. Quite frequently a No. 11 stoppered catheter is inserted and left in situ for hours. This is especially beneficial where it is impossible to get by the stone and the obstruction to the secretion is complete.—*The U. and C. R.*, 8, 20.

**CAPACITY OF THE BLADDER.**—W. A. Pearson (*Journal of the American Institute of Homeopathy*) made a study of the bladder capacity in 176 male medical students and found that the average was almost exactly 600 c. c. with a variation from 165 c. c. to 1,450 c. c. The average bladder capacity of seven women was found to be 382 c. c. with a maximum of 551 c. c. and a minimum of 260 c. c.

**OBSERVATIONS ON THE HEMATURIA OF CHRONIC INFECTIOUS FOCAL NEPHRITIS.**—R. F. O'Neil (*Internat. Jour. of Surg.*, 1920, XXXIII, 72) is of the opinion that the relation of idiopathic hematuria to nephritis is too constant to be a coincidence, and thinks that nephritis is the underlying cause. In treating unilateral hematuria, it is essential to determine whether the nephritis is of toxic or of infectious origin. In order to reach a diagnosis as

to the cause of renal symptomless hematuria, all causes of bleeding must be carefully eliminated, with the aid of all the modern diagnostic means. The usual symptoms are bleeding from the kidney for a long time with very little discomfort, a feeling of heaviness, and a dull, aching pain on the side affected or in the back, not influenced by rest or motion. Sometimes this pain is colicky, and extends down the ureter. The urine commonly contains blood and albumin, and sometimes pus. In hematuria from chronic infectious focal nephritis, nephrectomy should not be performed. After determining that the hematuria is unilateral, one should confine the procedure to freeing adhesions and performing decapsulation and fixation or nephrotomy. While decapsulation and nephrotomy have given equally good results, the author considers the former as the safer operation.

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### PATHOLOGY

Conducted by JOHN G. WURTZ, M. D.

NOTE ON THE PRESERVATION OF SPECIMENS OF BLOOD INTENDED FOR BLOOD SUGAR DETERMINATIONS.—Denis and Aldrich (*Jour. Bio. Chem.*, October 1920, xlv, 203), recognizing the need of preserving blood or blood filtrates, have experimented with various preservatives and arrive at the conclusion that one drop of commercial "formalin" (containing 40% formaldehyde) to 5 cc. of oxalated blood is an efficient preservative and in no way interferes with sugar estimations. The dropper employed delivers 30 drops to the cubic centimeter. While formaldehyde is ordinarily classed as a weak reducing agent, they found that even amounts ten times greater than used as a preservative, produces no formation of cuprous oxide. Blood specimens have been kept four days at temperatures ranging from 20 to 33 degrees Centigrade by the addition of formalin, without glycolysis.

EPEDEMIC ENCEPHALITIS: INCLUDING A REVIEW OF 115 AMERICAN CASES.—Dunn and Heagey (*Amer. Jour. Med. Sc.*, October 1920, p. 568) give a review of the work done and observations made during the study of encephalitis. They group the cases into 8 types; polioencephalitic, lethargic, Parkinsonia, cataleptic, meningitic, cerebral, polyneuritic and myelitic. These types are not strictly true types, but such a classification aids in the study and recognition of cases. Ocular disturbances were most common symptoms and next in frequency was lethargy. Polypnea, catalepsy, headache, rigidity of the neck, tremor, disturbances in reflexes, perspiration and fever occurred in about the order named. Laboratory findings were a mild leukocytosis averaging 10,200 with a polymorphonuclear percentage of 72. The Wassermann was uniformly negative. Blood cultures were sterile except in one case which yielded a green streptococcus which was agglutinated by the patient's serum. The urine showed only the usual findings associated with acute infections. The spinal fluids were clear, the intraspinal pressure was increased, the average number of cells was 9 with a marked predominance of lymphocytes. In some instances there was found an increase of globulin.

A STUDY OF THE CORRELATION OF THE BASAL METABOLISM AND PULSE RATE IN PATIENTS WITH HYPERTHYROIDISM.—Sturgis and Tompkins (*Arch. Inter. Med.*, October 1920, 26, 467), recall that tachycardia has long been recognized as being associated with hyperthyroidism and dwell upon the more recent means of determining the presence of this condition by metabolism



studies. The writers made intensive studies in the Peter Bent Brigham Hospital, upon cases of hyperthyroidism, particularly as to the relationship of the pulse to increased basal metabolism. Their observations they summarize as follows: "A study of the resting pulse rate and basal metabolism in hyperthyroidism shows that there is a fairly constant relationship between the two in a high percentage of instances. In a study of 496 basal metabolism determinations on 154 patients with hyperthyroidism, there was a tachycardia of 90 or more to the minute associated with a basal metabolism of plus 15 per cent. In seventy instances when the metabolism fell to normal there was a simultaneous fall in pulse rate in 78 per cent to below 90. In fifty-two patients on whom a number of metabolism determinations were made, the pulse rate gave an accurate idea of the course of the disease as compared to the basal metabolism in 85 per cent. In a series of 106 hospital patients with various diagnosis and normal basal metabolism, only five had a heart rate of 90 or more per minute." Provided other obvious causes of tachycardia can be eliminated, the majority of patients with hyperthyroidism, or in those in whom the diagnosis is in doubt, a persistent heart rate of 90 or over indicates an increased metabolism. An extreme tachycardia suggests a greatly increased metabolism while a slight tachycardia usually indicates a slight or moderate increase.

BLOOD PRESSURE IN UNIVERSITY FRESHMEN AND OFFICE PATIENTS.—Alvarez (*Arch. Int. Med.*, October 1920, 26, 381), after extensive observations upon both males and females of various ages, opines that pressures over 130 mm. for women and over 140 mm. for men are abnormal. Between 16 and 40 the mean pressure was 115 mm. for women and 126.5 mm. for men. He found the blood pressure much more uniform in women than in men and further that high pressure appears earlier and to a greater degree in men than in women.

## DERMATOLOGY

Conducted by RALPH BERNSTEIN, M. D.

ETIOLOGY OF PSORIASIS.—The evidence supporting the nervous or parasitic origin of psoriasis is reviewed by Bory. Of 129 cases occurring in soldiers, over 80 per cent were of recent development, and in only twenty-six cases did the first appearance of the condition date prior to the age of 20. The evidence points strongly to tuberculosis, that is, to an infectious or parasitic origin.—*Jour. Amer. Med. Asso.*

ECZEMA OF THE LIP.—According to Montgomery and Culver, among the cases of eczema of the lip are to be found a group of dry, scaly, precancerous affections. A dry, scaly line forms from side to side across the lip, situated about midway between the cutaneous border and the summit. It may stretch from one corner of the mouth clear across to the other, or the line may be broken. It may be a roughened, brown line of dry epithelium, or it may be a narrow, brown, faceted line. They believe this line to be the same as seen in the "rosebud mouth" of the infant, and to represent the junction in the fetus of the mucous membrane resembling the cutaneous surface with the mucous membrane resembling that of the oral cavity. It is in this line, when roughened, than an epithelioma is likely to develop, and the recognition of this line is of importance because the epithelial degeneration

extends along it for a considerable distance on each side of the epithelioma proper. Therefore, any operation failing to take this into consideration is likely to fail because it is not inclusive enough.—*Journ. Amer. Med. Assoc'n.*

COMMON ORIGIN OF VARICELLA AND CERTAIN CASES OF HERPES ZOSTER.—Netter has compiled a record of 59 cases in which herpes zoster was followed by chicken pox in the contacts, and ten cases in which varicella was followed by cases of herpes zoster. This connection between varicella and zona was evident in three cases in his service. Several cases of one of these diseases developed after a case of the other, with scarcely a possibility of contagion from outside. The intervals were about the same as the intervals with varicella. In sixteen of the cases the two diseases ran their course in the same person almost simultaneously. The eruption which sometimes develops along the course of herpes zoster resembles closely that of varicella.—*Bull. de l'Academie de Medecine, Paris.*

VACCINE THERAPY IN FURUNCULOSIS OF INFANTS.—Treatment of furunculosis in infants by vaccine therapy is recommended by Langer. He employs a commercial vaccine and the injections are given daily, from 500 to 1,000 million bacteria being employed. He reports the danger from secondary infection as less with intramuscular than with subcutaneous injections. Two or three injections will usually bring about remarkable results. It has been shown that the new-born infant lacks the power of forming specific antibodies. Therefore, Langer is rather inclined to class the favorable effect of vaccine therapy under the head of nonspecific protein therapy. Older children, who have developed more or less fully the power of forming antibodies, require for this reason a different treatment.—*Therapeutische Halbmonatshefte, Berlin.*

ABSORPTION OF VISIBLE AND ULTRA-RED RAYS BY THE SKIN.—Sonne announces as the result of his extensive research that the arm can bear without burning 3.11 calories per minute of the visible rays and only 1.79 per minute of the "inner ultra-red" rays and 1.33 per minute of the "outer ultra-red" rays. None of the latter are reflected back from the surface while 35 per cent of the visible and of the "inner ultra-red" rays are reflected back, leaving only 2.02 calories to be absorbed; hence this figure represents the amount of the visible rays that can be absorbed without burning. The temperature at the surface of the skin may therefore be 43.8 C. under exposure to the visible rays, but 45.5 C. under the "outer infra-red" rays. With the latter the temperature decreases down to body temperature at a depth of 1 cm., while with the visible rays the temperature increases with the depth to a certain point—about 0.5 cm.—where the temperature reaches 47.6 C. (117 F.). At this point, the temperature with the infra-red rays is only 41.7 C. Summing up he concludes by saying that with exposures of the skin to the light rays we are able to raise the temperature of the blood in and under the skin higher than can be realized by or with the strongest bearable dark heat rays, the difference possibly amounting to as much as 5.8 degrees centigrade.—*Jour. Amer. Med. Assoc'n.*

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 Joseph Samuel Hepburn, A.M., B.S., Philadelphia.  
 William M. Hillegas, M.D., Philadelphia.  
 John A. Holland, M.D., South Ashburnham, Mass.  
 Charles B. Hollis, M.D., Philadelphia.  
 Geo. A. Hopp, M.D., Philadelphia.  
 David Wilbur Horn, Ph.D., Bryn Mawr, Pa.  
 Thomas W. Jackson, M.D., Harrisburg, Pa.  
 Aug. Korndoerfer, M.D., Philadelphia.  
 N. F. Lane, M.D., Philadelphia.  
 R. S. Leopold, M.D., Philadelphia.  
 F. H. Lutze, M.D., Brooklyn, N. Y.  
 Wallace McGeorge, M.D., Camden, N. J.  
 L. E. Marter, M.D., Philadelphia.  
 H. L. Northrop, M.D., F.A.C.S., Philadelphia.  
 Winfred Overholser, A.M., M.D., Westboro, Mass.  
 Gilbert I. Palen, M.D., F.A.C.S., Philadelphia.  
 Charles R. Palmer, M.D., West Chester, Pa.  
 O. H. Paxson, M.D., Philadelphia.  
 Robert L. Piper, M.D., Tyrone, Pa.  
 Eldredge C. Price, M.D., Baltimore, Md.  
 Hon. W. T. Ramsay, Chester, Pa.  
 C. Sigmund Raue, M.D., Philadelphia.  
 H. Malcom Read, M.D., York, Pa.  
 Moses T. Runnels, M.D., Kansas City, Mo.  
 Phillip J. R. Schmahl, M.D., New York City.  
 Wm. A. Seibert, M.D., Easton, Pa.  
 Chas. H. Seybert, M.D., Philadelphia.  
 A. Clement Shute, M.D., Pottstown, Pa.  
 C. Seaver Smith, M.D., New Haven, Conn.  
 E. S. Snyder, M.D., Lancaster, Pa.  
 James G. Spackman, M.D., Wilmington, Del.  
 Deacon Steinmetz, M.D., F.A.C.S., Philadelphia.  
 John P. Sutherland, M.D., Boston, Mass.  
 Everett A. Tyler, M.D., Philadelphia.  
 Helmuth Ulrich, M.D., Boston, Mass.  
 F. L. Van Sickle, M.D., Harrisburg, Pa.  
 A. B. Webster, M.D., Philadelphia.  
 G. Harlan Wells, M.D., Philadelphia.  
 H. O. Williams, M.D., Lansdale, Pa.  
 William Rendell Williams, M.D., Philadelphia.  
 John E. Wilson, M.D., New York City.  
 John G. Wurtz, M.D., Pittsburgh, Pa.





# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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JANUARY, 1920

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**A Manual of Hygiene and Sanitation.** By Seneca Egbert, A.M., M.D., Professor of Hygiene, University of Pennsylvania, formerly Professor of Hygiene, and the Dean of the Medico Chirurgical College; Sometime Major, Medical Corps, U. S. Army; Member of the American Medical Association, American Public Health Association, etc. Seventh Edition enlarged and thoroughly revised, illustrated with 160 Engravings and 5 plates. Lea and Febiger, Philadelphia and New York, 1919. Price \$3.00.

The revision of Egbert's Hygiene for the present edition has been thorough and every chapter has been gone over in order that its contents shall be abreast of the times. The conservatism of the author in retaining much of the old and in taking up some of the newer matters that have claimed attention of late is to be commended. Much of the old material in scientific matters relates to fundamental principles which always remain the same and must be kept in the foreground. Mere novelty has its glamour but is never a sufficient warrant for giving space to what is not yet wholly established by experience. Nevertheless, considerable new matter has been added and the book is brought thoroughly up to date and is worthy of the continuance of the patronage it has had in the past. Special attention has been given to the Hygiene of Industry and Occupation. As to size, the volume is midway between the compend and the elaborate treatise. It is therefore, a Manual for Physicians.

**The Future of Medicine.** By Sir James Mackenzie, F.R.S., M.D., F.R.C.P., and LL.D. Ab. & Ed., F.R.C.P.L. (Hon.) Consulting Physician to the London Hospital. Henry Frowde, Hodder & Stoughton, Oxford University Press, 20 Warwick Square, E.C.4., 1919.

We have before us a small volume nicely printed on rough surface

paper in good type pleasant to read, by an author who has become eminent by reason of his supreme common sense. Anything that he has to say concerning the future of medicine deserves consideration by physicians. The subject is considered in three parts; namely, Critical, Personal Experiences, and constructive. The first part which deals with medical education and medical research, has already been reviewed by us editorially. "Personal Experiences" in the second teaches us how a general practitioner may, with a relatively small experience in any one department of medicine do wonderful work if based on a logical plan and moderate industry. The third part considers the practical application of the teaching of parts one and two. The volume is made up of nineteen essays, the perusal of any one of which must make a better physician of the reader. Dr. Mackenzie is one of the few champions of the general practitioner as opposed to specialists with restricted knowledge of general medicine.

**Pocket Manual of Homœopathic Materia Medica.** Comprising the characteristics and guiding symptoms of all remedies (clinical and pathogenic). By William Boericke, M.D., Professor of Homœopathic Materia Medica and Therapeutics at the University of California; Author of "A Compend of the Principles of Homœopathy." Associate Editor of "The Twelve Tissue Remedies," etc., etc. Seventh edition, revised and enlarged with the addition of a repertory by Oscar E. Boericke, M.D. Published by Boericke and Runyon, New York, 1920.

Dr. Boericke's pocket Materia Medica makes a new bid for Professional patronage in its seventh edition. The book supplements every other work on Materia Medica and if used as a ready reminder of the essential facts of our symptomatology and as an introduction to the larger books of reference it will more than fulfill its purpose.

The work before us is in no sense a treatise and must not be considered or judged as such. It is as accurate and reliable a compilation and the largest collection of Materia Medica facts and clinical suggestions as it is possible to obtain in the present state of our experience or knowledge.

The Repertory or third part of the volume by Dr. Oscar Boericke is one of the most concise and logical arrangements of the kind it has ever been our good fortune to peruse. We believe that owners of the volume will agree with us.

Boericke's Materia Medica is printed on very thin paper and bound in limp leather. Although of 1115 pages it can readily be carried in the side pocket of a sack coat.

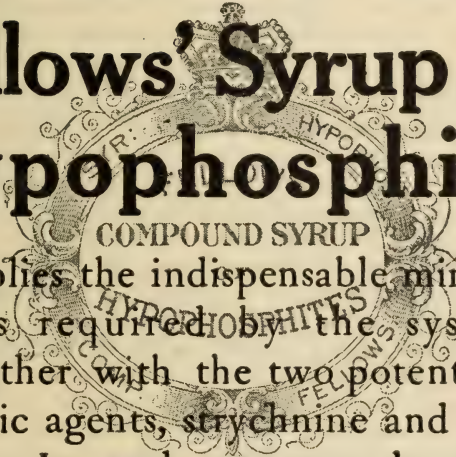
**The Medical Treatment of Cancer.** By L. Duncan Bulkley, A.M., M.D. Senior physician to the New York Skin and Cancer Hospital, etc. Philadelphia, F. A. Davis Company, Publishers. English Depot: Stanley Philips, London, 1919.

Dr. Bulkley's book herewith introduced is most readable. Whether or not his ideas work out in practice remains to be seen. Certainly his teachings bear the impress of sincerity. Personally we doubt their soundness. We believe that it is a wrong doctrine to inculcate that operative cases of cancer can or should be treated by any other methods than the knife; and the earlier, the better, without resorting to lines not accepted by experience. The main point made by Dr. Bulkley, is that dietetic factors play a very important part in the production of cancer



Chronic Invalidism is a  
very frequent sequel of  
Influenza.

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salts, required by the system  
together with the two potent dy-  
namic agents, strychnine and qui-  
nine. It accelerates convalescence  
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SAMPLES AND LITERATURE UPON REQUEST

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and that its prevention and cure are to be effected by altering the patient's feeding habits. There can be no objection to carrying out Dr. Bulkley's ideas after operation. We would protest, however, against using them exclusively. If experience shows the value of the author's teachings following operations we are then justified in proceeding still farther in our clinical observations of them.

**Diseases of the Nervous System**, a text book of Psychiatry and Neurology by Smith Ely Jelliffe, M.D., Ph.D., formerly professor of Psychiatry, Fordham University, New York; and formerly Adjunct Professor of Diseases of the Mind and Nervous System, New York Post Graduate Medical School and Hospital; and William A. White, M.D., Superintendent of St. Elizabeth's Hospital, Washington, D. C.; Professor of Nervous and Mental Diseases, Georgetown University; Professor of Nervous and Mental Diseases, George Washington University; and Lecturer on Psychiatry, U. S. Army and U. S. Navy Medical Schools, Third Edition, Revised, Rewritten and Enlarged, Illustrated with 470 engravings and 12 Plates; Lea and Febiger, Philadelphia and New York, 1919.

The present edition has been remodeled and largely rewritten. New data in the fields of vegetative neurology and of the endocrinopathies have accumulated in large volume in the last two years; the authors have done justice to these acquisitions in knowledge by a careful selection of material which will best serve the practical purpose of the Student and Practitioner; at the same time they have arranged the chapters that the student may see the trend of the development in this rapidly enlarging field which underlies a dynamic understanding of all physiological and pathological processes going on, not only within the nervous structures themselves, but in all of the organs themselves.

The chapters on sensorimotor neurology have been carefully revised to accord with the many new observations which the Great War has afforded, and the many confirmations of existing hypotheses relative to this large sphere in nervous diseases.

In the third part the enlargements have been mostly along the lines of an interpretative presentation of the Psychoses, with an increased emphasis on the description of the mechanisms involved rather than the grouping of certain symptom-complexes under conventional captions.

Throughout the book the authors have continued the endeavor, projected in the original plan, to build up a conception of the interrelation and interdependence between the several divisions of the subject which is their characteristic in nature, but which for the practical purposes of presentation they have artificially separated under three headings.

**Philadelphia County Homœopathic Medical Society.** The regular meeting of the Philadelphia County Homœopathic Medical Society was held at Hahnemann Medical College, Thursday, December 11, 1919. The meeting was called to order at 9:15 P. M. by the president George W. MacKenzie, M.D.

The report of the committee on legislation, Theodore J. Gramm, M.D., chairman, was presented. It is the opinion of the committee that there will be an adequate amount of alcohol allowed for professional use each year to Homœopathic physicians. James P. E. Scott, M.D., was elected a member of the Society. There were twenty-three applications for



# DEBILITATED WOMEN IN PREGNANCY

*The difficulties experienced by debilitated women during gestation are best met by rest, suitable diet and a blood-maker such as*



*The value of Cord. Ext. Ol. Morrhuae Comp. (Hagee) in this state lies in its unite power to make blood, add strength to the tissues and store up energy. And it is extremely palatable, too.*

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## THE EASTON SANITARIUM EASTON, PA.

**P**HYSICIANS and friends desiring to place any aged invalid or mild mental patient in a quiet, select, well-furnished home where they will receive the best of care, will do well to visit this place before deciding elsewhere.

Booklet sent on application.

C. SPENCER KINNEY, M.D.,

(Late First Assistant Physician at the Middletown State Homoeopathic Hospital, New York.)



Northrop's contribution in connection with these cases proves the benefits which accrue from team work.

Joseph V. F. Clay, Secretary.

**The Homœopathic Medical Society of Germantown** held its regular monthly meeting at Kugler's Restaurant, 1421 Chestnut St., on Monday evening, December 15th, the President Dr. Ernest L. Clark in the chair. Routine business was transacted. The old Board of Governors was re-elected with the exception of Dr. Charles M. Brooks who absolutely declined renomination. Dr. E. M. Howard was elected in his place. The retiring members of the Entertainment Committee, with the exception of Dr. Theodore Gittens, were re-elected. Dr. Gittens declined further service on the Committee and Dr. William W. Speakman was elected in his place. Nominations for officers for the ensuing year were then made. Dr. Howard S. Busler, Dr. Wm. Schemeley and Dr. Adolph H. Friedmann were elected to membership.

At 9:30 the scientific program was called and consisted of a Symposium on Pneumonia by the Clinical staff of Hahnemann Hospital. It was given as follows: Introduction and Etiology by Dr. Clarence Bartlett, General Symptomatology by Dr. G. Harlan Wells, Physical Diagnosis by Dr. William R. Williams, Diagnosis and Treatment by Dr. G. Morris Golden and Treatment by Dr. Oliver H. Paxson. The Symposium closed at 10:40 after which dinner was served. Eighty-five members were present.

**Homœopathic Medical Society of the County of New York.** The regular meeting of the Homœopathic Medical Society of the County of New York was held at the Academy of Medicine, 17 West 43rd St., Thursday, Dec. 11, 1919. The meeting being called to order at 8.15 P. M. by the President, Dr. S. B. Moore. Attendance 48.

The minutes of the last meeting were read and approved. Dr. J. L. Sengstack, Flower Hospital, was elected to active membership. The Annual Reports of the Secretary and Secretary to the Executive Committee were read and on motion were approved, accepted and ordered placed on file. The annual report of Treasurer showed total receipts of \$984.72, Disbursements \$503.52, leaving a cash balance of \$481.20. The chair appointed Drs. Raynor and Ver Nooy committee to audit the Treasurer's accounts and report at the next meeting of the Society. The Committee on Legislation, Dr. Sprague Carleton, Chairman, reported in part as follows: "We have done considerable work on the 'Compulsory Health Insurance Bill.' This form of insurance as practised abroad, (especially in England) has been a flat failure. Individual effort should be made to reach those in power in the attempt to defeat the passage of the bill."

The Executive Committee made the following recommendations with reference to complimentary dinner to Dean Preston. That a public dinner be tendered Dean Preston, Jan. 17, 1920, under the auspices of the Homœopathic Medical Society of the County of New York, in which medical men and women and their friends be invited to participate, and that the following committee be appointed to make necessary arrangements: Dr. George F. Raynor, Chairman and Drs. F. M. Dearborn, Wallace B. House, John F. Rankin and E. D. Rudderow. On motion regularly seconded these recommendations were unanimously adopted.

The following were nominated for active membership by Dr. J. H. Fobes and regularly seconded, John E. Fortsch, M.D., 1 West 68th St.,



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N. W. Thompson, M.D., Metropolitan Hospital, J. C. Railey, M.D., 250 Lexington Ave., R. C. Eckhardt, M.D., 616 Madison Ave., M. J. Wilson, M.D., 135 West 78th St., J. C. Howard, M.D., Flower Hospital and D. E. Brace, M.D., 235 East 57th St.

The Bureau of Drug Proving and Clinical Research, D. E. S. Coleman, M.D., Chairman, presented a paper entitled "Treatment of Drug Addiction at the Riverside Hospital," by Robert J. Wilson, M.D., Director of Bureau of Hospitals, Department of Health, City of New York.

Dr. Wilson spoke extemporaneously, showing very clearly the classes of cases treated, the need for proper classification of them and regretted the City's inability to continue the follow up treatment, or to have a prolonged period of convalescence, so that patients could be kept under proper observation until all tendency to relapse had been eliminated. Most of these cases treated at the Riverside Hospital should be termed "arrested cases" and not cases of cure.

Dr. Joyce one of Dr. Wilson's co-workers spoke also of these cases and of their treatment and said in part as follows: "Sixteen hundred cases of drug addiction have been treated at the Riverside Hospital, with a mortality of but two. Seventy-five per cent. of these cases come from the underworld and 90 per cent. of them have been users of heroin. We must help these patients into other channels of life, must have long treatment for convalescence, at least six weeks is necessary. Custodian care is absolutely essential and the longer the period of custodian care the better the chances are for a return to normal physical and mental health. There are three stages, 1st, Preparatory, 2nd., Elimination or withdrawal and 3rd., Convalescence. 1-250 of a grain of Hyosine is given hypodermically and it is rarely necessary to repeat dose more than 11 to 14 times, even in the worst cases.

"The injections may be repeated at two or three hours intervals if the symptoms present so warrant."

In the general discussion which followed Drs. J. S. Gaines, John Hutchinson, G. S. Harrington and R. A. Benson, propounded questions to Dr. Wilson.

Dr. Wilson spoke briefly in closing and answered the queries of the discussors.

On motion regularly seconded and unanimously carried a most cordial vote of thanks was tendered Drs. Wilson and Joyce for their timely and instructive addresses.

Under the same Bureau, Dr. John Hutchinson read a very thoughtful and instructive paper entitled "A Proving of Morphine." In the discussion which followed, Drs. Rushmore and Stearns spoke in appreciation of the paper.

The tellers at this time reported the unanimous election of the following as officers for 1920: President, J. H. Fobes, M.D.; Vice-President, R. A. Stewart, M.D.; Secretary, Charles Ver Nooy, M.D.; Treasurer, E. W. MacAdam, M.D.; Necrologist, P. C. Thomas, M.D.; Censors, S. B. Moore, M.D., W. F. Honan, M.D., Grace Kahrs, M.D., F. M. Smith, M.D., and C. T. Sibley, M.D.

The Committee on Eye, Ear, Nose and Throat, William McLean, M.D., Chairman, presented a very clear and concise paper entitled "Sphenoidal Sinusitis, Its Diagnosis and Treatment," by Samuel Knopp, M.D.

This paper was discussed by Drs. S. H. Vehslage and G. S. Harrington.



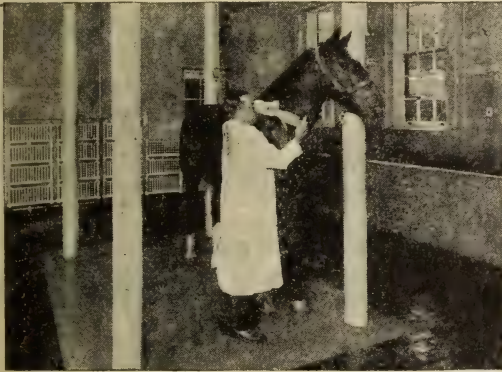
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**The Difficulties and Inconvenience** of separate injections of Antipneumococcic Serum and Antistreptococcic Serum may be avoided by using **Mulford Pneumo-Strep-Serum**, which is prepared by injecting horses simultaneously with the fixed types I, II and III of pneumococcus, also some strains from group IV pneumococcus, and 15 key strains of streptococcus.

**Pneumo-Strep-Serum**, therefore, possesses the combined ad-

vantages of antipneumococcic and antistreptococcic serums. It contains antibodies against all the various strains of pneumococcus and streptococcus employed, and, by standardization against type I pneumococcus, it is equally as potent against type I pneumonia as the type I and polyvalent antipneumococcic serums.

**An injection of 100 mls Pneumo-Strep-Serum is equivalent to 100 mls Antipneumococcic Serum and 100 mls Antistreptococcic Serum.**



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# Mulford

Dr. J. S. Gaines spoke of a Directory in process of evolution by the American Institute of Homœopathy, in which the charge of "Commercialism" in advertising names, etc. of homœopathic physicians was made, and on motion of Dr. Gaines, seconded by Dr. Whitney the motion was unanimously carried that the matter be referred to the Executive Committee for investigation and report.

Meeting adjourned at 10:25 P. M.

Charles Ver Nooy, M.D., Secretary.

**Homœopathic Medical Society of the State of New York.** The next annual meeting of this Society will be held at the Hotel Ten Eyck, Albany, N. Y., April 13th and 14th, 1920, for which occasion every arrangement has been made by Dr. Cochrane, Chairman, for the comforts and entertainment of the visitors and members. The Legislative Committee composed of Drs. Schenck, Heeve and Van Loon are conducting active propaganda to prevent the passage of the Compulsory Health Insurance Bill. This bill is a pernicious one and has powerful political backing and will require the united efforts of physicians to kill it. The scientific program will consist of reports from the hospitals. Dr. R. M. Jones representing the New York Ophthalmic Hospital and its staff will present a paper on Syphilitic Conditions of the Nose and Throat. The Buffalo Homœopathic Hospital will give a Symposium on Acidosis. The Hahnemann Hospital of Rochester will likewise have an excellent paper, the title of which has not yet been received. From every standpoint the meeting promises to be a live one, demanding the attendance of every Homœopathic Physician in the State of New York.

**Homœopathic Medical Society of the State of New York.**—The Executive Committee were in session on the evening of November 8th and plans for the winter and the spring meeting were further advanced.

The Membership Committee under the leadership of Dr. B. B. Clark of New York, has been enlarged by the addition of the following members:

Dr. L. A. Martin, Binghamton; Dr. J. L. Dowling, Albany; Dr. J. F. Rankin, Brooklyn; Dr. L. S. Henry, Syracuse; Dr. A. R. Grant, Utica; Dr. H. G. Keith, Yonkers; Dr. W. D. Duckworth, White Plains; Dr. C. E. Lane of Poughkeepsie; Dr. J. M. Lee, of Rochester; Dr. R. M. Schley, Buffalo; Dr. R. B. Howland, Elmira; Dr. C. A. Potter, Gowanda; Dr. R. C. Woodman, Middletown; Dr. A. H. Hardy, Mt. Vernon; Dr. J. H. Fobes, New York City.

Dr. Clark has assigned a definite number of names of Homœopathic physicians throughout the State who are not members of the State organization to each member of his committee and each one of the committee is definitely responsible in securing applications from the names assigned to him. This is in addition to the work done by the President who made a personal appeal by letter to every Homœopath in the State.

The plans for the protection of the members against malpractice suits instituted against them is being put into shape by Dr. F. M. Dearborn. The doctor will have the matter in such shape at the Albany meeting that the Society can take immediate action.

Already the programe outline by the bureau which was assigned to Flower Hospital has been completed and the schedules for its papers for the April meeting have been filed. So, also has Utica, which will present papers on Gall Bladder Disease. The Medical Treatment and



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Never was there a time when tonic treatment was so generally needed as it is today. In convalescence from *influenza*, *bronchitis*, *pneumonia* and the *fevers*, in *indigestion*, *neurasthenia* and *nervous ills* and whenever a restorative remedy is indicated, Gray's Tonic *will not fail*.

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New York City



Diagnosis by Dr. H. L. Pender, Radiographical Diagnosis by Dr. M. W. Johns and the Surgical Treatment by Dr. A. R. Grant.

Dr. R. M. Jones, chairman of the bureau assigned to the New York Ophthalmic Hospital, has inspired the gentlemen selected to present a paper from that institution and Dr. Deady has forwarded letters to every member of the staff stating that the work that they were to assume would be on "Syphilis of the Eye, Ear, Nose and Throat." The collective data gathered during the year from such a well supplied clinical institution will make an exceptional paper.

The bureau chairman of Brooklyn, Dr. O. S. Ritch, reports that Dr. H. B. Minton, who has the work in charge, has selected "Diseases of the Lungs" as his topic. Collaborative papers from Cumberland Street Hospital on Bronchitis, Pneumonia and Influenza are to be presented by Dr. J. Wright, A. Bornmann, H. Hale, M. Fleckles and H. B. Minton. It is to be hoped that the comparative of figures will be reported showing the overwhelming success of this institution in the treatment of Influenza, during the last winter, the hospital at that time being under control of the Navy.

Roy Upham, President

### HAHNEMANN COLLEGE NOTES.

Chas. R. Hutcheson, Editor-in-Chief.

**Musical Clubs.**—Both the orchestra and Glee Club are progressing remarkably, having recently had several trial concerts. A most valuable adjunct to the club has recently been acknowledged by the willingness of Dr. Fennimore, president of the Fortnightly Club of this city, to lend his efforts in training the Glee Club. Dr. Fennimore has a remarkable ability along musical lines and with his assistance we certainly look for big things in the future.

Through the ardent efforts of the management, arrangements are being made with the Lafayette College, whereby the Hahnemann Clubs may possibly unite with those of Lafayette for a combined concert in the very near future.

**Athletics.**—The basket-ball team is now playing at its best. We have a good team and are proud of the support given by the student body. The City League games are hotly contested and the winner of the cup is in no way assured. Osteopathy, Textile, P. C. P., Temple and Hahnemann all have good teams on the floor. A schedule of four games each after Christmas will decide the winner of the cup. The standing of the teams is as follows:—

	Won	Lost
Temple .....	3	0
Hahnemann .....	2	1
Osteopathy .....	2	2
Textile .....	1	2
P. C. P. ....	0	3

With Hahnemann winners over P. C. P. 37-16 and over Osteopathy 31-27, the outlook appears very good. The team composed of Capt. Toomey, Bewer, Pierson, Miller, Haas, Richards, Lichtenwalner, Guyler and Briggs, are looked upon to bring the laurels to Hahnemann.

Games have been scheduled with Ursinus, St. Josephs, Wilmington M. E. Church, Penn. Fresh, Drexel and other very good quintets. We

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NOW KNOWN AS SUCH TO ALL DISPENSING  
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As a safeguard against having worthless imitations of the preparation dispensed, it is suggested that the physician use the name

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which is non-descriptive and more distinctive, when prescribing GLYCO-HEROIN (SMITH) for **Cough, Asthma, Phthisis, Pneumonia, Bronchitis, Laryngitis, Whooping-Cough and kindred affections of the respiratory system.**

**DOSE**—The adult dose is one teaspoonful every two hours, or at longer intervals as the individual case requires.

For children of ten years or more, the dose is from one-quarter to one-half teaspoonful; for children of three years or more, five to ten drops.

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The composition of GLYCO-HEROIN (SMITH) has not been modified in the slightest degree.

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New York, U. S. A.

hope and believe the support of the student body will continue as enthusiastically as in the past.

**Senior.**—On Thursday, Dec. 11th, a most interesting and instructive address was given to both the Juniors and Seniors by Dr. Rudolph Rabe, Professor of *Materia Medica* in the New York Homeopathic Medical College. Dr. Rabe is a man of great renown in medical circles and it was indeed a pleasure to have him with us. Dr. Rabe spoke on "The Repertory" explaining at what times and just how it should be used. His well drawn illustrations and his vast knowledge of *materia medica* are indeed to be commended. It suffices to say that we appreciate his presence as well as his most instructive and interesting talk.

Indeed one-third of the term has elapsed with its many varied coincidences. The section in obstetrics has experienced some very high class demonstrations along its particular line. Of these, the most marked has been the recent delivery of triplets, all living. The first child was delivered as a breech presentation while the other two were delivered by internal podalic version and extraction. An obstetrical treat was the opinion of those present; according to statistics this is the first of its kind at the hospital, being a full term delivery. The father, when told over the phone, thought it was a "joke," but found to his surprise, after visiting the hospital that it was far from such.

The Secretary of the class, Mr. Cecil Hancox, deserves much credit for the manner in which he has succeeded in getting such a vast variety of samples from the various manufacturing houses for the men of the class. Indeed, some are of a character to be very useful to the men, not only at present but also as occasions present themselves in the future.

The appointments at the Pittsburg Homœopathic Hospital have been made and we congratulate the following men: Reuter, Gibbardt, Tuter, Haneox, Mathewson and Sheets. We know they will do good work, and we wish them the best of success. Norman Stevenson goes to Chester, Scholtes and Ginrick to Reading, Burkett to Wilmington, Gardner to Utica Homœopathic Hospital, while the others, being yet uncertain, will be announced later.

Echoes from the Medical wards:—

Doctor: How does the temperature fall in Typhoid Fever?

Echo: By "Lysol," doctor.

Through the ingenuity of one of the students of the medical section, the plan has been devised whereby we may derive a complete "urine analysis" from "Gastric contents."

**Juniors.**—Christmas vacation has come and gone only too quickly and the Junior class is down to genuine hard work preparing for the mid-years. Many of us have been warned by the present seniors that we would find this a most difficult year, and indeed we have. The sub-sections in the dispensaries and special clinics have changed as usual after the holidays.

It is rumored that the jewelers did a rushing business with certain members of the class during the holidays and that "Hank" Goeken will soon have some new recruits to his married men's club.

**Don't forget the 1921 Year Book.**

In order that the famous Junior songs may not be lost to future classes, it has been suggested that they be compiled in book form and be made a prerequisite in the future.

McCleary wishes to warn those Juniors who vote the Democratic



# There Are Ten Million Syphilitics in America

—Of course, you would like to know the most approved methods in the diagnosis and treatment of this disease.

—The results of the latest research pertaining to its pathology and clinical manifestations.

—To be familiar with the facts relating to its economic bearing upon society.

—To have at your disposal the experience of a group of the best-known syphilographers of the present day.

—You get this information and more pertaining to this subject in the new book.

## SYPHILIS

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By Henry H. Hazen, A.B., M.D.

Professor of Dermatology and Syphilology, Medical Department of Georgetown University; Professor of Dermatology and Syphilology, Medical Department of Howard University; Member of American Dermatological Association and National Association for Control of Syphilis; Visiting Dermatologist and Syphilologist to Georgetown University Hospital, Freedmen's Hospital, Washington Asylum Hospital, and Woman's Evening Clinic; Author of "Diseases of the Skin," "Cancer of the Skin," etc.

650 pages, 6 x 9, with 160 illustrations in the text, and 16 color plates.

Price, silk cloth binding, \$6.50.

Doctor Hazen has prepared the first book that covers the whole field of syphilis in an authoritative way. Special sections have been written by Major M. A. Reasoner on Infection and Immunity; Dr. H. A. Fowler on Syphilis of the Male Genito-Urinary Organs; Dr. John Dunlop on The Bones, Joints, Muscles, Tendons and Bursæ; Dr. John Lind on Central Nervous System; Drs. Virginius Dabney and L. H. Greene on the Ear and Eye; Col. Charles F. Craig on Wassermann Reaction in Diagnosis and Treatment; Dr. Jay F. Schamberg on Toxicology and Therapeutic Testing of Arsphenamine; Capt. Walter Van Sweringen on Diagnosis of Syphilis from Radiographer's Standpoint; Dr. Edward H. Reede on Endocrine Glands. The beautiful photomicrographs form a distinctive feature of this book.

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ticket not to mix politics with a medical education, especially in Dr. Bornemann's pharmacy.

**Sophomores.**—The class has now adopted an official class song, having been approved by Mr. Kratz in whose presence we have had several rehearsals.

Quite apropos to our course in Physiology is the demonstration exhibited by one of our members in regard to reflexes. He has developed or inherited one all of his own; and so fascinating and complex is it in nature that he has had many mimickers, and although they have practiced hard and faithfully, none have acquired the same beautiful, unconscious, coordinated action.

**Freshmen.**—It can hardly be realized that nearly half of the college term has passed. Yet we do realize that a vast amount of work has been covered, and while the time is rapidly fleeing, yet we feel that the accumulated knowledge, in proportion, far exceeds that of the time spent. Seems as though every man at Hahnemann is "On the Job," giving those fundamentals that are very essential to a successful Homœopathic physician.

At the end of next year, those students who advance successfully and who have spent their Science years at Hahnemann will receive the Degree of Bachelor of Science. In order to acquire this degree an original thesis must be presented to the Faculty. The boys have already started research work along these lines and we all wish much success to "Charlie" White, who has made a grand attack on the question of the Hydrogen Ion Concentration.

The class is very glad to have Dr. W. M. Sylvis as lecturer in Anatomy. Dr. Sylvis with his pleasing personality and ability as a lecturer, instils into the men a desire to grasp the subject with a renewed vigor. Under Dr. Sylvis' careful guidance, a most interesting and instructive course in Anatomy is certainly anticipated.

"Hen" Ruth boasts that he gets his hair cut every week.

"Frenchy" makes boasts he can chew more tobacco than his "Dad."

"Art" White can argue about "Nothing" in a very capable manner.

**Second Year Science.**—The second year Science class held their second annual dance at the Eastern Travelers' Club, on Nov. 18th. The members of the class spent a pleasant evening together, the occasion being a marked success. Each and every man was on hand at college the next day, probably due to the marked change since July 1st.

The boys in France who so nobly withstood the attack of the Germans have nothing on the members of our class, who are making a manly stand against the combined attacks of Dr. Horn and Prof. Schmidt on Saturday mornings.

We are glad to welcome back our good friend Ralph Bohn who has been confined to the hospital for a short period of time. Glad to have you back, Ralph.

At last the Irish are becoming civilized, "Mickey" Maley has been seen wearing a wrist watch.

**First Science.**—It is indeed a pleasure to learn of the recovery of our fellow classmate, Claire Thomas, who has recently undergone an operation in the hospital. We hope to have him with us soon again.

Everybody sympathizes with "Cort" Quimley. His specimen in Biology was a Cod shark instead of a Cod-fish. Of course he is very much concerned about it and so are we, but he says that doesn't remedy the fish.

The "First Science Glee Club" as a unit has temporarily disbanded,

Vol. 1

DECEMBER, 1919

No. 2

# BÉNOL

A carefully prepared and standardized emulsion of pure benzyl benzoate, each mil. contains .0625 grammes (30 grs. per fluid ounce).

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**A harmless nontoxic; non-narcotic; habit-free antispasmodic**  
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\* *Journal of The American Medical Association* 599-601, Aug. 23, 1919.





due to considerable criticism around the college. We hope to practice in the very near future, and then try again.

"Here's hoping we prove satisfactory."

Prof. Schmidt's physics course is making athletes of some of us. The other day "Cupid" Cannon went tearing up the stairs, running through the halls, finally halting at the fourth floor. Dr. Pearson waylaid him in his rampage and informed him that the college was no "race track." "Beg your pardon, Doctor" said "Cupid" (all out of breath,) "but I'm finding my horse power."

The first science is going to run a dance in the near future and all anticipate a very pleasant occasion.

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**Treasurers Report.**—Enclosed find report of Secretary and Treasurer, which I hope you will publish for the enlightenment of the Medical Profession of Pennsylvania. The following amounts, per counties, was received by your Treasurer as follows:

1917—from the three State Medical Societies of Pennsylvania, each \$25.00—\$75.00; Adams, \$8.00; Allegheny, \$424.00; Armstrong, \$17.00; Beaver, \$55.00; Blair, \$50.00; Bradford, \$6.00; Bucks, \$19.00; Butler, \$16.00; Cambria, \$45.00; Carbon, \$8.00; Clearfield, \$33.00; Clinton, \$7.00; Chester and Delaware, \$24.00; Columbia, \$12.00; Crawford, \$14.00; Cumberland, \$12.00; Dauphin, \$33.00; Delaware, \$20.00; Elk, \$23.00; Erie, \$35.00; Fayette, \$9.00; Franklin, \$4.00; Greene, \$21.00; Indiana, \$55.00; Jefferson, \$2.00; Juniata, \$2.00; Lancaster, \$67.00; Lackawanna, \$17.00; Lawrence, \$21.00; Lehigh, \$5.00; Lebanon, \$20.00; Luzerne, \$95.00; Lycoming, \$33.00; Mercer, \$64.00; Mifflin, \$20.00; Montgomery, \$84.00; Montour, \$9.00; Monroe, \$15.00; McKean, \$42.00; Northampton, \$131.00; Northumberland, \$62.00; Philadelphia, \$681.50; Reading, \$15.00; Schuylkill, \$82.00; Somerset, \$14.00; Sullivan, \$2.00; Tioga, \$3.00; Warren, \$50.00; Wayne, \$18.00; Westmoreland, \$11.00; Wyoming, \$9.00; York, \$112.00; Miscellaneous Contributions, \$30.48. Total, \$2,741.98.

The expenditures for printing, postage, telephone calls, telegrams, stenographers, attorneys fees, traveling expenses of Committee, the Secretaries expenses and the expenses of the President, amounted in all to \$2,254.42, leaving a balance in the hands of the Treasurer of \$487.56.

This furnishes your Committee with a balance for constructive Legislative work. The work of the Medical Profession in the past has been purely of an obstructive character, but it is the effort of the Medical Legislative Conference of Pennsylvania, to go forward with the work for the benefit of the people of this State; through their Medical Representatives to place the Medical Profession on a basis second to none in this country.

This we can do with active and united effort. Thanking the profession through your columns, for their support in the past year and craving a continuance of that support, we remain

Very truly yours,

E. A. Krusen,

Sec'y and Treas. for Conference.

---

#### DEATHS.

Richard Leiman, Detroit; Detroit Homœopathic College, 1910; aged 36; a member of the Michigan State Medical Society; while on a hunt-

# The Growing Popularity of Boiled Milk in Infant Feeding

Boiled milk has been shown to be more easily digested by infants than raw milk, and certainly is to be preferred to milk of any but unquestionable quality. That boiled milk feedings correct vomiting and most cases of diarrhoea is a matter of common observation.

## Normal Babies

fed on boiled milk dilutions are frequently constipated. For these cases we recommend

## Mead's Dextri-Maltose, No. 3

The potassium carbonate present acts as a corrective in constipation and normalizes the infants' stools. As a rule the diet can be so regulated that the administration of cathartics can be avoided.

## Babies Having Suffered from Diarrhoea

When plain boiled milk and water (or barley water) feedings have been instituted after the usual period of starvation, as soon as the stools become normal, the addition of carbohydrates to the diet is desirable. We recommend

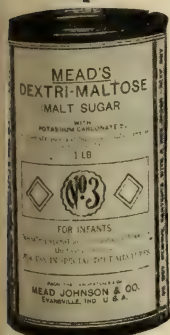
## Mead's Dextri-Maltose, No. 1

It can be used with less danger of recurrence of diarrhea than other forms of sugar. It supplies quickly available energy, which babies in this weakened condition so greatly need. The sodium chloride present, as well as the malt sugar, aids in the retention of water by the tissues, which have been partially dehydrated by the diarrhoea. The weight lost during the period of sickness is usually quickly recovered, and a normal gain may be expected thereafter.

*Reprints of late researches on Boiled Milk and also Literature and Samples of Dextri-Maltose, mailed on request.*

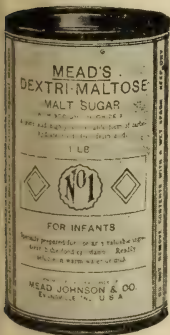
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Moisture . . .	5%



### COMPOSITION

Maltose . . .	52%
Dextrin . . .	41%
Sodium Chloride . . .	2%
Moisture . . .	5%

ing expedition, near Parry Sound, Ont.; was accidentally shot and killed, November 8th.

Clayton Welch Seaman, Buffalo, N. Y.; New York Homœopathic Medical College, New York City, 1896; aged 50; a member of the Medical Society of the State of New York; Visiting Physician to the Buffalo Homœopathic Hospital, and Ingleside Home; died November 13th from tuberculosis.

Louisa Schlegel, Brooklyn, N. Y.; New York Medical College and Hospital for Women, Homœopathic, New York City, 1889; aged 72; died November 23rd from arteriosclerosis.

James B. Williams, M.D., a graduate of the University of Pennsylvania, 1880, and of the Hahnemann Medical College of Chicago, 1890, died at his home in Chicago, on November 18th, of arterio-sclerosis, aged 62.

Lena Grace Spring, M.D., a graduate of the Hering Medical College, 1904, died November 2, 1919, at the age of 49 years.

James M. Walker, M.D., of Denver, Colorado, a graduate of the Homœopathic Medical College of Missouri, 1871; for six years a member and for three years president of the State Board of Medical Examiners; a veteran of the Civil War, died at his home on December 3, 1919, at the age of 71 years.

Christian Pickhardt Haller, M.D., a graduate of the Hahnemann Medical College of Philadelphia, 1902, died in Bridgeport, Conn., on November 9, 1919. Dr. Haller was honorably discharged as captain of the M.C., U. S. A. on May 11, 1918, because of physical disabilities.

Lionel Rideout Lumby, M.D., a graduate of the Homœopathic Department of the University of Michigan, Ann Arbor, died at his home in Pontiac, Mich., November 21, 1919, of angina pectoris.

Homer W. Osborn, M.D., a graduate of the Homœopathic Hospital College of Cleveland, 1871, died at his home in Cleveland on November 26th, 1919, of heart disease.

Laurence Frank Keith, M.D., a graduate of the Boston University School of Medicine, 1907, died at his home in Wareham on September 19, 1919, of valvular heart disease.

## PERSONALS

Joseph W. Post, M.D., announces his return from the service and is now in association with Frederick K. Ream, M.D., D.D.S., 708 Medical Arts Building. Practice limited to Roentgenology.

Dr. David Wilbur Horn, Professor of Hygiene at Hahnemann College, delivered an illustrated lecture on "Cocoa and Chocolate" a popular account of the fruit of the tropical tree, Theobroma Cacao and its uses, before the Delaware County Institute of Science on November 24, 1918.

Dr. Edward K. Golding resumed practice at 211 North Sixth Street, Reading, Pa., September first.

Dr. Dudley J. Morton, announces that he has been released from military service and will resume the practice of Orthopedics at 1421 Spruce Street, Philadelphia. Office hours: Tuesday and Friday only 9 to 11 or by appointment. Telephone, Spruce 2333.

Dr. Walter E. Lang has entered upon his duties as Superintendent of the State Hospital for Mental Diseases at Westborough, Mass. Dr. Lang previous to his entrance into the service had extensive psydiatric experience at Easton and Allentown. He was discharged from the service with the rank of Major on June 3rd, 1919.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

FEBRUARY, 1920

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### Food for the Sick and the Well, How to Select It and How to Cook It.—

By Margaret P. Thompson, Registered Nurse. Cloth, ix + 82 pages.  
Price \$1.00. Yonkers-on-Hudson, New York; World Book Company.

This is a book of receipts, the result of many years of experience in arranging, changing and adapting them so as to form a well regulated diet for the sick and for convalescents, as well as for those who are well and wish to remain so. The housewife as well as the physician and the nurse will find in this volume a valuable help and guide. The text discusses the relation of food to health and the necessity of a balanced menu.

**Homœopathic Medical Society of Philadelphia.**—The regular monthly meeting of the Homœopathic Medical Society of the County of Philadelphia was held in the ampitheatre of Hahnemann Hospital, Thursday evening, January 8, 1920.

The meeting was called to order by the president, Dr. G. W. MacKenzie at 9:15 o'clock.

The minutes of the last meeting were read and approved.

The committee on Legislation, Dr. Theodore J. Gramm chairman, reported that probably the Internal Revenue Department at Washington would not require a bond from Homœopathic physicians for the use of alcohol in their practice of medicine and that probably the amount per year allowed to each physician would be 15 gallons.

The committee on the President's address, Dr. H. S. Weaver chairman, presented their report; it has been placed in the minute book.

Dr. E. M. Gramm, secretary pro tem, reported that the resolutions presented at the December meeting were sent to the Philadelphia County Medical Society, and that he had received no reply.

The Board of Censors approved the following applications for membership, and on motion by Dr. C. Bartlett seconded by Dr. C. S. Raue, they were elected members of the Society:

John V. Allen, Jr., Chas. O. W. Bartine, William A. Doebele, H. W. Doyle, Donald R. Ferguson, Chas. J. Hahn, Carroll F. Haines, Harold W. Lambert, William R. Lewis, Clarence J. Lewis, William L. Martin, Harry P. Metzger, Newlin F. Paxson, R. Randolph Paxson, Thomas W. Phillips, John H. Reading, Jr., Alfred R. Seraphin, Frederick G. Stubbs, Thomas M. Snyder, H. A. Taggart, Carl V. Vischer, R. A. Walther and Henry P. Webb.

The following committee on membership was appointed by the President: Dr. Frank F. Barthmaier, Dr. Donald Ferguson, Dr. Paul Wittman.

Dr. G. J. Alexander presented a clinical case of Carcinoma of the Larynx wherein radium was used for 72 hours, with a fatal result. Dr. G. A. Hopp gave a demonstration of how to collect blood specimens for red and white cell count; also for Wasserman reaction. Dr. G. Harlan Wells demonstrated a simplified method of administering neo-arsphenamine. Dr. S. W. Sappington demonstrated the technique of collecting specimens of spinal fluid and also intra-spinal injections. Dr. G. W. MacKenzie demonstrated the preparation of remedies for use in auto-therapy. On motion meeting adjourned at 10:55 P. M.

Theodore K. Gramm, Secretary.

**Homœopathic Medical Society of the County of New York.**—The regular meeting of the Homœopathic Medical Society of the County of New York was held at the Academy of Medicine, 17 West 43rd Street, Thursday, January 8, 1920, the meeting being called to order at 8:05 P. M. by the President, J. H. Fobes, M.D. Attendance 60.

The minutes of the last meeting were read and approved.

On motion regularly seconded and unanimously carried, the Secretary was requested to cast ballot for the election to active membership of Drs. John E. Fritsch, 1 W. 68th St., N. W. Thompson, Metropolitan Hospital, J. C. Railey, 250 Lexington Ave., R. C. Eckhardt, 616 Madison Ave., W. J. Wilson, 135 West 78th St., J. C. Howard, Flower Hospital and D. E. Brace, 235 East 57th St. The Secretary announced their election on motion of Dr. McDuffie, seconded by Dr. Moore; the following were nominated for active membership: Drs. LeRoy Franklin, 103 West 77th St., A. L. Chambers, 58 Central Park West, S. W. Gregory, 469 West 144th St., Alphors Hertel, 2999 Perry Ave., J. A. McPhillips, 1 West 94th St., Frances W. Morell, 19 West 84th St., N. H. Lewis, 39 West 39th St., E. S. Pope, 17 East 38th St., F. L. Mosser, 784 Dawson St., S. D. Mundell, 964 Tiffany Ave., Moe J. Mayer, 1933 Madison Ave., George Norton, 30 East 55th St., G. H. Van Gillmore, Flower Hospital, L. B. Whitman, 567 West 186th St., S. P. Jewett, 1200 Madison Ave., A. E. Renner, 427 Park Ave., G. H. Taylor, 156 West 80th St., C. B. Reed, 1 West 68th St., W. D. Duckworth, Hahnemann Hospital, J. C. Hayner, Hahnemann Hospital, S. C. Roare, 156 West 84th St., W. A. Wilder, 116 Nassau St., Max Greenwald, 38 West 59th St. and H. L. Hermes, 332 East 30th St.

On motion regularly seconded and carried the President was requested to appoint a "Clinical Week Committee" of two members of the County Society to become a part of the "Clinical Committee" of the State Society. The President appointed Drs. G. F. Raynor and Sprague Carleton as said committee.

Dr. Moore the retiring President in a few earnest sentences thanked the various members of his cabinet for their efficiency and fidelity, spoke hopefully of the future of the Society and promised the President-elect his cordial and whole hearted support.

Chronic Invalidism is a  
very frequent sequel of  
Influenza.

# Fellows' Syrup of the Hypophosphites

supplies the indispensable mineral  
salts required by the system  
together with the two potent dy-  
namic agents, strychnine and qui-  
nine. It accelerates convalescence  
and restores strength and vigor

*"The Standard Tonic for Over Half  
a Century"*

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SAMPLES AND LITERATURE UPON REQUEST

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Dr. Fobes, President-elect spoke briefly, thanking the Society for the honor conferred. Realizing the importance of this Society in the Empire State, he hopes to maintain the high standard and if possible surpass it. He hopes to develop the scientific side of our activities. His closing sentence is worthy of our consideration, "If we hang together we can make this year a great success, if we do not it will be just one more reason for us hanging separately."

The Legislative Committee, Dr. F. M. Dearborn, Chairman, presented the following: "Resolutions relative to Compulsory Health Insurance offered at the regular monthly meeting of the Homœopathic Medical Society of the County of New York in the Academy of Medicine, Jan. 8, 1920.

Whereas: We the members of the Homœopathic Medical Society of the County of New York, recognize that it is an important part of our duty as physicians to safeguard the traditions of the science and art of medicine in all its branches, and to promote the efficiency both of the individual practitioner, as well as collective scientific endeavor to the end that we may preserve the public health and contribute to the well-being of the citizens of our State and county, and

Whereas: We feel the public has a right to expect from the medical societies of this County, proof of our confidence and loyalty in them.

Therefore, Be it resolved that we, the members of the Homœopathic Medical Society of the County of New York, assembled January 8, 1920, are uncompromisingly opposed to compulsory health insurance in any form, and that we feel that this legislation is partisan to a great degree, is un-American and unscientific and contains none of the elements of true economics, all of which facts can easily be proven by the operation of similar laws in Great Britain and Germany.

Be It Further Resolved, that we hereby urge the Governor and Members of the Legislature of this State, to use their best endeavor to defeat any bill embracing compulsory health insurance, by whomsoever introduced and in whatever form."

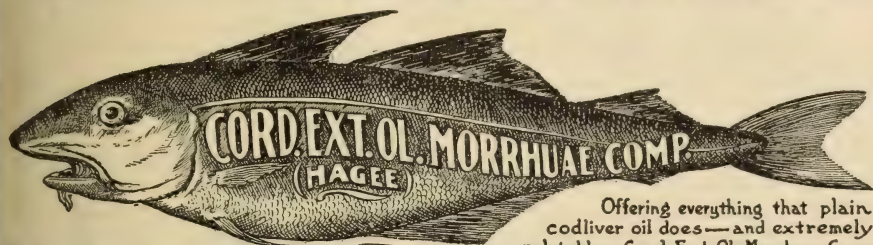
On motion of Dr. Dearborn, seconded by Dr. Moore it was unanimously voted that these resolutions be adopted by the County Society and that the Secretary be instructed to send a copy of the same to the Governor and each Legislator, duly attested by the officials of the Society and bearing the seal of the same.

Dr. J. Perry Seward, Chairman of Bureau of Materia Medica and Therapeutics, in a few well chosen words spoke in the highest terms of the scholarly and scientific attainment of Professor Hinsdale and assured those present of the rare treat in store for them.

"It gives me great pleasure to present A. E. Hinsdale, M.D., Professor of Materia Medica and Therapeutics, Ohio State University, who will speak on the subject, 'The Laboratory as an Aid in Teaching Materia Medica'."

Professor Hinsdale received an ovation when he arose to address the Society, spoke extemporaneously and held the undivided attention of all present for over one hour as he unfolded to us in his inimitable style his laboratory work, teaching his students Materia Medica with a materia medica on one hand and his micro-photographic plates on the other hand. These plates showed the condition of the muocus membranes of stomach and intestines of animals before medication and the changes which resulted after the use hypodermically of some homœopathic remedies. He showed also pulse tracings and sections of lungs and

**RE-ENFORCING THE AGED** patient's ability to withstand cold and changeable weather, and to meet the usual bronchial and pulmonary ailments, is a problem which



helps the doctor to solve.

TRY IT WITH YOURS THIS WINTER

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used as a mouth-wash, is considerable insurance against respiratory infections.

Katharmon Chemical Company, Saint Louis, Mo.

KATHARMON represents in combination Hydrastis Canadensis, Thymus Vulgaris, Mentha Arvensis, Phytolacca Decandra, 10½ grains Acid Borasalicic, 24 grains Sodium Pyroborate to each fluid ounce of Pure Distilled Extract of Witch Hazel.

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Booklet sent on application.

C. SPENCER KINNEY, M.D.,

(Late First Assistant Physician at the Middletown State Homoeopathic Hospital, New York.)

liver. He passed a large number of these plates among the members, so that we could see the contrasts, which were marked in many instances before and after the use of remedies. Before his eloquent and convincing array of facts, the men who have always contended that homœopathy is a scientific practice of medicine were well nigh jubilant, the doubters were almost persuaded and the skeptics had food for thought, which will probably result in work of a similar kind being done in New York. The practice of Homœopathy is not a lost art. We have only lost the vision.

Discussion was opened by Dr. R. F. Rabe, who spoke in part as follows: Dr. Hinsdale has added to his accomplishments that of an engineer. He has built a bridge over which the allopaths can come over into the Homœopathic fold. Visualization will be realized by the method of Dr. Hinsdale. Many satisfactory prescriptions have been made from subjective symptoms. Pathological findings are also helpful in making prescriptions. Other methods useful are modalities, pure and simple, causation and the repertory. We should use all methods of approach in treating disease. The valuable work of Dr. Hinsdale is deserving of greater publicity by our School and we hope some day in the near future he will publish his findings in book form.

Dr. G. F. Laidlaw: Dr. Hinsdale is a pioneer, he has broken the ice, he is the hammer, so to speak. We should criticize the old in the *Materia Medica* and not reverence it, as is the tendency today. Dr. Hinsdale is talking homœopathy in language which can be understood. The following questions were asked Dr. Hinsdale by Dr. Laidlaw: "Have you found that the right and left localizations have been verified? Have you had experience with inert substances such as silica, nat. mur and calc. carb? Did constipation and diarrhœa occur in all of the remedies used?"

Dr. Hinsdale answered no to the 1st and 2nd queries. To the third question he stated the effects were primary and secondary in character.

Dr. W. G. Crump: Commends work of Dr. Hinsdale. Is somewhat interested in Camphor in shock. Hahnemann says: "Camphor for shock must be given in large doses to get results."

Dr. Hinsdale spoke briefly in closing and thanked the Society for its cordial reception.

On motion of Dr. Moore, seconded by Dr. Rabe and unanimously carried, a vote of profound thanks was tendered Dr. Hinsdale for his interesting and instructive address.

President Fobes called on Dean Preston, who among other things said: "I feel that I need a large dose of *Veratum Alb.* as this is my first appearance at one of your meetings. I have enjoyed Dr. Hinsdale's address very much, and realize it is along lines which we must travel in the future if we are to hold our students, and graduate real homœopathic physicians."

On motion of Dr. Laidlaw, seconded by Dr. Rabe and unanimously carried, Dr. Hinsdale was elected an "Honorary Member" of this Society.

Dr. Hinsdale in a very captivating manner thanked the Society for the honor conferred, and said it had been a great pleasure and joy to him to address us.

Meeting adjourned at 10:45 P. M.

Charles Ver Nooy, M.D., Secretary.



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**Germantown Homœopathic Medical Society of Philadelphia.**—The regular monthly meeting of the Society was held at the Musical Art Club, January 19th, at 9:15 P. M., the President, Dr. E. L. Clark, in the chair. The appointed essayist for the evening, Dr. Ashcraft, was unable to appear because of illness. Dr. Earl V. Rice accordingly entertained.

The following were elected to membership: Drs. W. I. Tomlinson, R. Randolph Paxson, Fred. G. Stubbs and Chas. H. Seibert.

The election of officers at 10 P. M. resulted as follows: President, O. S. Haines, M.D.; Vice-President, William M. Sylvis, M.D.; Secretary, Howard F. Schultz, M.D.; Corresponding Secretary, Charles B. Hollis, M.D.; Treasurer, Irwin B. Gilbert, M.D.; Board of Censors: Nathaniel F. Lane, M.D., William A. Weaver, M.D., William Rendell Williams, M.D.; Board of Governors: Theodore J. Gramm, M.D., John D. Ward, M.D., E. M. Howard, M.D., John A. Fisher, M.D., Harry S. Weaver, M.D.

Following the election, Dr. Haines delivered an address on the "Future of Homœopathy," for which he received the thanks of the Society. Sixty-seven members were present notwithstanding the inclemency of the weather.

### EXAMINATION QUESTIONS, PENNSYLVANIA STATE BOARD OF LICENSURE, JANUARY 1, 1920.

**Practice and Materia Medica and Therapeutics—Hygiene and Preventive Medicine.**—1. What remedies and means might be utilized in the treatment of cystitis? State the principles, or indications, governing their use? 2. Outline the treatment of influenza, and also of its frequent and most serious complications? 3. Give the official name of four different purgatives, and state for what particular reason you would select them? 4. Write a prescription for an ointment for—(a) ringworm; (b) eczema; (c) impetigo contagiosa? 5. Name a normal food ration for one day as to amount of the different component parts. Name some of the common articles of diet in which the different needful ingredients of food are to be found? 6. Outline the medicinal as well as the general treatment of a case of diabetes mellitus. 7. Discuss briefly the subject of serology with special reference to three diseases of your own selection. 8. Give the dosage according to your system of practice, and the principal uses, or indications, of ten drugs. 9. Evaluate, (a) diet in nephritis; (b) purgation in typhoid fever, (c) sanitation in malaria? 10. (a) Name four diseases which may be insect borne? (b) Give practical methods for insect control?

**Physiology—Pathology—Bacteriology.**—1. Explain the significance of leucocytosis. Illustrate by two different clinical conditions. Explain the value of a differential blood count? Illustrate. 2. What is the significance of (a) a general lymphatic enlargement? (b) of a local enlargement? Illustrate and explain the phenomenon in each. 3. Describe the physiology of vomiting? Discuss (a) the types and (b) the causes of vomiting, outlining the laboratory aids in determining the cause of each. 4. Discuss briefly focal infection, (a) as to susceptibility; (b) as to frequent sources of infection, and (c) as to methods of transmission. 5. Describe the development of (a) thrombus, (b) furuncle (c) keloid, (d) carcinoma. 6. Explain (a) the process of repair following a traumatic fracture, (b) the pathological conditions that may induce fractures. 7. Give causes of (a) transient and (b) of continued polyuria. What laboratory findings would aid in determining the causes? 8. Describe the characteristic lesion in each of the three stages of syphilis. How may the diagnosis





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be confirmed in each stage? 9. Given a persistently swollen and painful knee joint, (a) describe the lesion. (b) What etiological factors should be considered? (c) How might each be proven? 10. Explain the principles involved (a) in the production of serum; (b) in the production of vaccines.

**Obstetrics—Gynecology—Chemistry.**—1. (a) Indicate a normal female pelvis by giving its measurements. (b) Describe three pelvic deformities which might interfere with a normal childbirth. 2. Given a woman supposed to be pregnant: (a) What signs and symptoms would you find in first (first 3 months) periods? (b) Second (4th and 5th months) period? (c) Third (last 4 months) period? (d) Give the relative height of the fundus each month from the end of the fourth month to the time of labor. 3. Name two varieties of toxemia of pregnancy, which might produce eclampsia and state the chemical difference. (b) Outline the management so as to prevent eclampsia. 4. (a) What conditions at the time of labor (before a vaginal examination is made) might lead you to suspect a breach presentation? (b) State the dangers to both mother and child. (c) Outline the delivery. 5. (a) Name three common uterine displacements. (b) State the causes of each. (c) Outline the successful management of each one. 6. Given a woman who has missed three or four menstrual periods, how would you determine it to be (a) intra-uterine pregnancy? (b) extra-uterine pregnancy? 7. What are the early symptoms and appearance of the cervix uteri that would lead you to make a diagnosis of cancer? 8. Discuss in detail the significance of the presence of albumin, of sugar and indican in the urine of the pregnant woman. 9. Name the pigments in the bile and in the feces. Discuss their relationship to each other. 10. (a) From what is gluten flour obtained? (b) Give the composition of gluten. (c) Discuss its food value.

**Diagnosis—Symptomatology—Toxicology and Medical Jurisprudence.**—1. Differentiate the two most frequent causes of hematemesis. 2. Give the incubation period and mention several important diagnostic points in each of the following diseases: measles, scarlet fever, diphtheria, small-pox. 3. Name three causes of acute hoarseness. Name four causes of chronic hoarseness. 4. Differentiate asthma as it may occur under each of three different causes. 5. Discuss the early diagnosis of typhoid fever both as regards symptoms and special findings. 6. If called to see a patient who has just become suddenly unconscious how would you differentiate between cerebral hemorrhage, uraemia, and post-epileptic exhaustion without going back to your laboratory? 7. What are the common diagnostic symptoms of chronic interstitial nephritis, and the typical urinalysis in such a case? 8. In a patient complaining of dyspnoea and palpitation and presenting cardiac arrhythmia, name three conditions that may cause such a symptom complex. On what associated symptoms would you differentiate them? 9. Describe the symptoms of three conditions in which jaundice is prominent? 10. What symptoms and conditions would be produced by drinking one-half fluid ounce of phenol? What treatment would you give in such an emergency?

**Surgery—Anatomy.**—1. (a) What is the most frequent location of fracture of the spine? (b) What portion of the vertebra is most frequently affected? (c) What injury to the vertebral column is frequently associated? (d) What are the dangers? 2. (a) In what direction does a simple dislocation of lower jaw occur? (b) What tissues are injured?

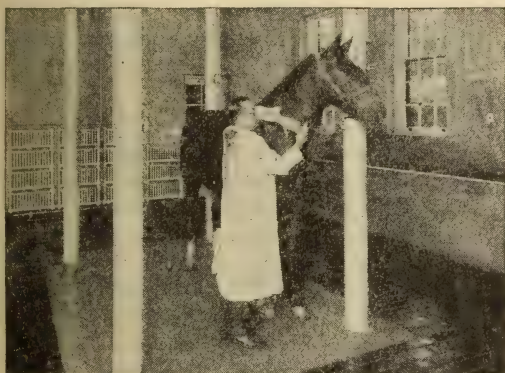
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(c) Name the muscles which aid in the production of the luxation. (d) What muscles resist its reduction? 3. Given an injury of the arm just above the anastomotica magna artery, in which the brachial artery is severed and in which the bleeding cannot be stopped in the wound, what treatment would you adopt? What danger would be involved in the treatment? What vessels would carry on the circulation? 4. What are the cardinal principles involved in the treatment of fractures of the long bones of the body? 5. What would be your choice of treatment in cases of accumulation of purulent effusion in the chest? Give the reasons. 6. What surgical conditions might be indicated by the ejection of blood through the mouth? 7. What possible surgical diseases might result from the continued presence of hemorrhoids? 8. (a) How would you advise a patient in order that he might avoid the development of an ingrowing toe nail? (b) How would you cure it without a cutting operation? (c) What are the principles underlying a surgical cure? 9. What are the causes of leg ulcers? (b) Why are they ordinarily difficult of cure? (c) Outline the better method of treatment, giving the underlying principle of the method. 10. Discuss fully the management of a patient coming to you suffering from a foreign body in the eye. (a) How would you discover it? (b) If on the surface, how would you determine whether or not it is imbedded? (c) In the event of its being imbedded or otherwise, how would you handle the case?

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**Complimentary Dinner to Dean Thomas Jex Preston, Jr., Ph.D.—**

Under the auspices of the Homœopathic Medical Society of the County of New York a complimentary dinner was tendered Dean Preston of the New York Homœopathic Medical College and Flower Hospital, at the Hotel Astor, Friday, January 16th, 1920.

About 250 members of the medical profession and their friends, ladies and gentlemen, were present, and enjoyed the choice viands provided, and the bright instructive and witty addresses made by those selected by the very efficient "Dinner Committee."

Dr. Joseph H. Fobes, President of the County Society presided, and in a few well chosen and appropriate sentences, introduced the four speakers of the evening, who held the close attention of all present.

The first speaker was Prof. Robert L. McElroy, Head of the Department of History of Princeton University, who captivated all by his charming personality, his free and commanding flow of choice language, ready wit, keen and telling logic and his reference in closing to the serious side of the times in which we are now living. He said he was sent to represent Princeton University; his Institution has every reason to be proud of her representative.

The address was one of rare merit and excellence.

Mr. Charles D. Barney, President of the Board of Trustees of Hahnemann Medical College, Philadelphia, brought cordial greetings from the oldest college in the world, and spoke in a delightful manner of Dean Preston and his work, and looks for still greater achievements by this college and its admirable Dean.

Dr. Charles E. Sawyer, President of the American Institute of Homœopathy spoke in a very earnest and forceful manner of our goodly heritage, of the vast amount of good work homœopathy has been able to accomplish throughout this Country, how all over the United States they look to New York for advancement in all medical lines, and expressed the hope that the future of our college under the guiding hand of Dean



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In closing Dr. Sawyer said: "The memory of this enthusiastic gathering will be a pleasant one, as I journey shortly to the Pacific coast in the interests of the American Institute of Homœopathy."

Rev. Henry Evertson Cobb, D.D., Pastor of the West End Collegiate Church, spoke earnestly and eloquently of how the professions of the clergy and medicine are interwoven, how they are both repairers and menders of souls or bodies, how they both endeavor to remake and rebuild lost virtue and impaired functions of the soul and body. In closing he spoke of the nobility of the practice of medicine.

Dean Preston spoke in part about as follows: "I thank the Society very heartily for the compliment, but do not consider it so much a personal compliment, as I do one for the institution which I have the honor to represent.

"A 'drive' will soon be made to secure money to place the college on a solid financial basis. We have faced some serious financial difficulties since I have been Dean, but so far we have been able to weather the storm, and we hope by co-operation and money (I do not know which we need most) to be able to make the institution what it should be, the best one in this country, (if not the oldest) or even in the world." In a very graceful manner he thanked the Faculty for their very arduous and efficient work, and stated that he had recently been told by a member of the American Medical Association, that he had the best Faculty now in the history of the college. When we consider the long list of illustrious men who have taught in this institution, does it not deserve your loyalty, hearty support and co-operation?

No report of this dinner would be complete without speaking in terms of the highest praise and appreciation of the unselfish work of the very efficient Dinner Committee, consisting of Drs. George F. Rayner, Wallace B. House, Frederick M. Dearborn and John F. Ranken.

If one may judge from the optimistic atmosphere presented by this representative gathering, the future of the college will be very bright.

May the financial clouds soon disappear, and all personal animosities be buried, and may we stand shoulder to shoulder working for the strengthening of the college, that it may be better equipped to prepare students to go forth from its halls of learning into the world of disease and promptly relieve human suffering which everywhere abounds.

Charles Ver Nooy, M.D., Secretary.

**New York State Society.**—The semi-annual meeting of the New York State Society was held at the Hotel Astor, January 16th, 1920. The meeting was called to order at 3:30 P. M. The Legislative Committee under the Chairmanship of Dr. H. D. Schenck, made a very complete report on the Compulsory Health Insurance Legislation and the members of the organization can be assured that they will be advised from time to time of the steps to be taken to aid in the defeat of this measure.

Dr. G. G. Mack, Treasurer, in her report, showed the Society to be on a firm financial footing.

Dr. O. S. Ritch, Chairman of the Committee on Inter-Society Organization reported that Federation with the Institute was well under way and that while it could not be put under way at this meeting, as the Constitution distinctly stated that it, the Constitution, could only be

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amended at an annual meeting. The work will be put under way at the Albany meeting.

Dr. F. M. Dearborn, Chairman of the Committee on Protective Insurance, in his usual concise and masterly manner, presented the amendments to the By-Laws which, when adopted in Albany will make Protective Insurance a great addition to the many benefits to be obtained from membership in the State Organization. The membership should realize that a number of other State Organizations throughout the country have worked out Protective Insurance for its members and after a very extensive investigation by Dr. Dearborn, who presented a most complete report to the Executive Committee, the feasibility of this measure is assured. Each individual, however, should obtain all the data possible and arrive at Albany prepared to speak intelligently on this measure. Your President feels that it will be a most efficient measure in increasing the membership of the organization. There are six hundred Homœopaths outside the State not affiliated with the Organization and it is not from lack of invitation that they have failed to be members of the Society. With this Protective Insurance added to their argument the Membership Committee should produce astounding results.

Dr. C. E. Sawyer, President of the American Institute of Homœopathy responded with one of his dynamic speeches which infused the members with enthusiasm for the Cleveland meeting.

The Constitution and By-Laws of the Organization being confused and having survived their usefulness, it was moved that a committee be appointed to consider the matter of re-writing a new Constitution and set of By-Laws and report at the April meeting.

The President of the Society also drew attention to the fact that the Transactions of the Organization were a great financial burden and that better results could be obtained by the publication of a quarterly journal. There were enough contributions to fill the journal and news items would keep the members in touch with all the movements of the Organization. It was moved a committee be appointed to report at the Annual meeting.

The speakers at the College Luncheon, occurring at one o'clock, April 14th, 1920, are: Dr. G. F. Laidlaw, President of the Alumni Association of the New York College; Dr. O. S. Ritch, Chairman of the College Committee; Dean Preston; Dr. Finley, New York State Superintendent of Education; Dr. F. M. Dearborn, Ex-president of the American Institute; Dr. L. A. Martin of Binghamton and Dr. D. B. Jewett of Rochester. It must be understood that this College Luncheon is for everybody and anyone attending the meeting no matter what his Alma Mater may be, must not under any circumstances absent himself from this function.

Dr. Clarence Mullens has been appointed Press Committee for the Albany meeting and he is beginning to fill the papers throughout the State with accounts of the Annual Meeting.

The Albany Committee on Arrangements will have a circular letter in the hands of the members, March first, which will cover all details of local arrangements and present the information which will make the visitor at home in Albany.

Dr. W. F. Fowler, Chairman of the Bureau of Surgery which was placed in the Hahnemann Hospital in Rochester, has reported the titles of his papers which are as follows: "The Complement-Fixation Test in Tuberculosis," by Dr. D. B. Jewett; "The Use of the X-ray in Pulmonary Tuberculosis with an Outline for Classifying the Cases," by Dr. J. B.

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### DEATHS.

Dwight Birdsall Hunt, Otego, N. Y., New York Homœopathic Medical College, New York City, 1873; aged 73; for many years a member of and Dean of the faculty of his alma mater; a member of the staff of the Homœopathic Hospital, New York City; died December 6th.

Harry Cook, Urbana, Ohio; Chicago Homœopathic Medical College 1894, aged 46; died in Grant Hospital, Columbus, Ohio, December 1st, from organic heart disease.

Edmund G. Shower, Baltimore, Hahnemann Medical College, Phila., 1878; aged 73; died suddenly December 10th, from neuritis, complicated by heart disease.

May E. Tracey Callender, Middletown, Conn; New York Medical College and Hospital for Women, 1865; aged 83; died November 1st.

Martha Hays Pollock, Harrisburg, Pa.; Boston University, School of Medicine, 1893; aged 74; died December 2nd.

Neidhard Hahnemann Houghton, Boston; New York Homœopathic Medical College, New York City, 1887; aged 58; associate professor of diseases of the nose and throat in the Medical Department of Boston University; died in the Massachusetts Homœopathic Hospital, Boston, December 26th, from injuries received when struck by a street car in Brookline a short time before.

Edward C. Ellerbrock, St. Louis; Homœopathic Medical College of Missouri, St. Louis, 1896; St. Louis College of Physicians and Surgeons, 1902; aged 64; died in the St. Louis City Hospital, December 25th, from accidental poisoning by bichloride of mercury.

Harry J. Garber, Essexville, Michigan; Homœopathic Hospital College, Cleveland, 1889; aged 53, died in Grace Hospital, Detroit, December 17th, from carcinoma of the esophagus.

Warren Cushman Hewitt, Xenia, Ohio; Homœopathic Hospital College, Cleveland, 1888; aged 54; a member of the Ohio State Medical Association for sixteen years, resident physician to the Ohio Soldiers and Sailors Home, Xenia, died December 18th from heart disease.

William B. Ellis, Concord, Mo.; Homœopathic Medical School of Missouri, St. Louis, 1888; aged 73; a Confederate veteran, also a dentist; died December 20th from heart disease.

John Lewis Metzger, Jr., Philadelphia; Hahnemann Medical College, Philadelphia, 1912; aged 29; died in Hahnemann Hospital, Philadelphia, December 9th, from heart disease.

### HAHNEMANN COLLEGE NOTES.

Chas. R. Hutcheson, Editor-in-chief.

**Seniors:**—With the advent of the year of 1920, a thrill of joy gleamed over the class, for this is the year that the men have looked forward to with such ardent anticipation. With the premedical year, the class began with forty men, but alas, not all of those have continued and become seniors. At present there are twenty-four men of the original class,



Vol. 1

DECEMBER, 1919

No. 2

# BÉNOL

A carefully prepared and standardized emulsion of pure benzyl benzoate, each mil. contains .0625 grammes (30 grs. per fluid ounce).

Benzyl Benzoate is a harmless non-toxic, non-narcotic, antispasmodic possessing marked effect on the smooth or involuntary muscles.

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  10. **Spastic constipation**—Relieved by the antispasmodic action on the smooth muscles of the lower bowels and intestines.
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\* *Journal of The American Medical Association* 599-601, Aug. 23, 1919.



along with 13 men who have at different times entered our ranks, so that we now total 37 in all.

The following men are to be congratulated as being selected as internes at the Hahnemann Hospital for the year 1920-1921: Doyle, Gault, Guillian, Kern, Kistler, Mark, Maitz, Mutch, Ross and Townsend. We know they will all do good work and feel confident that their term will be most successful.

Echoes from the various clinics: Medical Clinic. Professor.—“Gentlemen, what is the condition of this patient?” Dignified Senior.—“Has a marked degree of jaundice, Doctor.” Professor.—(Very profoundly.) “Wonderful. If you will scrutinize more carefully you will note he is a Chinese.”

Surgical Clinic: Professor.—(Demonstration with a patient.) “We have here a tumor of the mouth. What is your opinion as to the diagnosis?” Student.—“Euclepias, doctor.” Professor.—“A most wonderful God. The tumor is an epulus.”

**Juniors:**—It seems almost unbelievable that out of a class of fifty-three men there should be such a small amount of news, but the very fact that we are Juniors will account to a large extent for our lack of activities in other directions. We indeed find this a year of close application and the necessity of “burning the midnight oil.” Now that the mid-years are safely past (passed, we hope) we are for the first time in a position where we may really hope to be Seniors and thus gain a clearer vision of that elusive goal for which we have so long been driving, namely graduation and a degree.

Practically every man in the class is taking a genuine interest in his work and as we come under the most excellent teaching of our various professors, we are swayed by the eloquence of each in turn and consequently many a man sees visions of himself as an able obstetrician, only to find out by the time he has listened to a succeeding lecture, that he was all wrong and that his line without doubt should be surgery or gynecology or even the G. U. specialty, which, for various reasons, seems to hold quite an attraction. In the end we are very much like the small boy who was so fond of horses that he decided he would be either a mounted policeman or the driver of a coal team. His preference as an occupation tended toward the policeman's job, but the fact that the coalman had two horses at his command quickly clinched his decision in favor of an extra horse.

In the end we will all come back to earth and decide first of all to become good general practitioners, and better than that, good Homœopaths.

“Then sell ‘curentur pills’ we will and hope to luck our pockets fill.”  
From O. Ziegler's “Languid Lines.”

**Sophomores:**—At a very recent date, our friend and teacher, Dr. Rufus B. Weaver, celebrated his fiftieth wedding anniversary and it is needless to say that not only the Sophomore class but the College as a unit extend their most hearty congratulations. We were honored by a few informal remarks which made those who had already taken the initial step confident and beam with satisfaction; while those less fortunate, have been enthused with a new determination. Our very best wishes to both the Doctor and Mrs. Weaver, trusting that they enjoyed to the utmost their “second honeymoon” in the South.

By error, one of our men has come in possession of twenty feet of gas

# JOURNAL of the AMERICAN INSTITUTE of HOMEOPATHY

The Official Publication of the Organization.

SARAH M. HOBSON, PH.B., M.D. .... Editor

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## To Our Subscribers

Help the Editorial Committee of the Hahnemannian Monthly to make a better and larger journal by telling about us to your friends, and ask them to become subscribers. By each one doing a little, the aggregate result will be great. Send checks to the order of the Hahnemannian Monthly, 1435 Spruce St., Philadelphia.



pipe, several gas range fittings and three or four loose bricks. These were accidentally placed in his suit case, and the gift was not discovered until he had gotten home. If the owner will identify same and pay return freight charges, he may have said articles without question.

**Freshmen:**—Several of our men have become very popular for their various achievements. "Hick" Brewer has become champion dog meat grinder. He has won the championship from "Jack" Nash.

Much praise has been awarded the class for their very high class of music in the laboratories, but it is suggested that it had better cease, in view that it has such a charming effect on the other classes. The most popular song seems to be "Lulu." "Freudy" Marks and "Hen" Ruth seem to know more about "Lulu" than anyone ever heard.

Much congratulation is offered J. Harwood Closson, 3rd, who was recently elected as Vice-president of the class to succeed the past officer who has left college.

"Freddy" Moherley said he is sorry but he ran out of "Hand Grenades" for the Histological laboratory.

Due to the most excellent teaching of our Professor Bernstein on the Principles of Homœopathy, our class has indeed become imbued with the true spirit of Homœopathy. His thorough knowledge of the subject and wonderful teaching ability, has instilled into our hearts a most ardent love for Homœopathy.

We regret very much the loss of Dr. Steinhilber as one of our professors, in order to associate himself with another department of teaching. Dr. Steinhilber has given us a most wonderful course in Histology and his ability as a teacher and a friend of the student cannot be too highly estimated.

**Second Year Science:**—With the first half of the college year gone, we are now looking forward to the time when we will be full fledged medical students, having successfully gone through the two years of premedical work.

We wonder how "Doctor" Aquilino likes his new glasses? They are very becoming, Joe. Make you look like a real college professor.

Notice to Haberdashers: "Mukey" Maley is on the market for a new overcoat.

"Question Box" Vischer is at it again. He tells Professor Erwin that he understands French very well—If it was spoken in English.

Prof. Schmidt to "Noise" Umstead: "Have you got ten seconds to spare?"

Umstead: "Yes, sir."

Professor: "Then tell me what you know about Physics."

**First Year Science:**—It is with much satisfaction that we receive news from the Hospital that Claire is very much improved. We're certainly glad to hear such news and hope he will soon be in our midst.

Saturday afternoons are spent enjoyably by some of our men in Prof. Schmidt's "Labor Battalion."

It is with much pleasure that we welcome Von Buelow and Cumius back to our midst, after a short absence from college.

\$500.00 reward offered for the explanation as to why Crellin has been so quiet the last few days.

With the mid-years over, "Brad" Hoke and his committee of Sea-Lions are out of their cage. They offer us real live entertainment. This is their job, why shouldn't they?

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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MARCH, 1920

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**Therapeutics of the Respiratory Organs.** By Francis Cartier, M.D. former interne of the Hospitals of Paris; Laureate of the Faculty (Medal for Thesis); Former Physician of the Hospital Saint-Jacques; Ex-President of the Homœopathic Society of France; Corresponding member of the American Institute of Homœopathy and of the British Homœopathic Society, etc. Translated from the French and edited by Carl A. Williams, M.D.; recent attending physician, Memorial Hospital, New London, Conn.; Attending physician, City Hospital, St. Petersburg, Florida; member of the American Institute of Homœopathy, etc. Authorized Translation. Boericke & Tafel, Philadelphia, 1919. Price \$2.25 net.

We have in this volume a resume of the therapeutics of the respiratory organs translated from the French by Dr. Carl A. Williams. The subject matter is devoted exclusively to Homœopathic therapeutics, no attention whatever being paid to diagnostic matters and comparatively little to auxiliary treatment. In other words, the book is exactly what it claims to be. Those who are fond of dissertations by the presentation of dissociated symptoms will be disappointed in it for it is not that kind of book. It is one in which is presented material that has stood well in the experience of the author. Necessarily, then, the captious will criticize for what the book is not, instead of accepting it for what it is, the latter being the factor upon which judgment must be passed.

The pages devoted to the consideration of Homœopathic doses should be valued by our readers.

Dr. Williams' translation is unabridged. Its literary style is most excellent and entire freedom from involved phraseology highly noteworthy.

**Industrial Medicine and Surgery.** By Harry E. Mock, M.D., F.A.C.S., Assistant Professor of Industrial Medicine and Surgery at Rush Medical College. Octavo volume of 846 pages with 210 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$10.00 net.

The conservation of the lives and limbs of the working people and the reclamation of those disabled in the daily strife have become a definite program in the industrial world. The humanizing influence of this work has caused many an employer to consider other means of contributing to the health, comfort and contentment of his working force. Wherever these principles have been adopted, the industry has been awarded by greater efficiency among its employees, with a corresponding increase of production.

With the growth of this form of medicine the field has extended into the living and home conditions of the working forces, gradually resulting in closer cooperation with the public health authorities. In fact, it has become a vital factor in public health. Today the achievements of the industrial medicine and surgery are one of the strongest arguments in favor of a National health program.

It is scarcely more than ten or a dozen years since the majority of leaders in the medical profession could see nothing but a questionable future or a lowering of the prescribed ethical and scientific standards for the company doctor. Employees themselves at first gave the latter scant respect. Now all is changed. The term "company doctor" if used at all, is employed inadvertently. We now hear of the industrial physician or surgeon, who is an expert or a specialist in his branch. He now finds himself envied by his confreres in general practice. As with all other pioneers they were forced to blaze their own paths. By their force they have at least constructed easy roadways over which others may follow. What appeared to be a "humdrum" subject turns out to be one of great scientific possibilities as is well demonstrated by the subject matter of the book before us; in fact, to the men on the sidelines looking on the field is one full of surprises.

The subject matter is considered in six separate headings as follows: Industrial Health Service, Prevention, Industrial Medicine, Industrial Surgery, Compensation Insurance, Medico-legal Phases, Reconstruction. The book is therefore a necessary one for the library of the specialist. It will be more than useful to the general medical man practicing in industrial communities.

**Progressive Medicine.**—A Quarterly Digest of advances, discoveries, and improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics, Materia Medica, and Diagnosis in the Jefferson Medical College, Philadelphia. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia. December 1, 1919. Owners and Publishers Lea & Febiger, Philadelphia and New York. Six dollars per annum.

This volume affords a ready reference to literature covering the various subjects scheduled for the past year, and is especially convenient



Chronic Invalidism is a  
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Influenza.

# Fellows' Syrup of the Hypophosphites

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a Century"*

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SAMPLES AND LITERATURE UPON REQUEST

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for physicians to whom large files of journals are not accessible, such for example as are found in the large medical libraries. As usual we find the excerpts presented with comments of practical value by the various editors. We note with special gratification the return of Dr. E. H. Goodman, whose comments on literature have always seemed to us as being endowed with more than the average of common sense, and as such all the more readable. It is announced that for 1920, *Progressive Medicane* will be published in cloth binding only.

**Oxford Medicine.**—Edited by Henry A. Christian and Sir James Mackenzie. Volume I, part 5. New York; Oxford University Press, American Branch.

The present fasciculus is made up of 4 essays, as follows: The Rationale of Clinical Diagnosis by Lewellys F. Barker; Tests of Function, by Henry A. Christian; Respiration in Disease, by Francis W. Peabody; and Calorimetric Methods of Study in Disease, by Eugene F. DuBois.

Of these the following may be said: The first two essays are of intense interest to the general medical practitioner. That by Dr. Barker comprises 66 pages of the booklet and reviews the line of thought to be employed in working out difficult and it might be added problems that are not difficult. In other words it shows the importance of the rules of logic as applied to medicine. If its lessons are taken to heart, if the physician reads between the lines, its practical lessons are inestimable. Aside from this, the literary style is such as to make it most interesting reading.

Tests of function by Christian is more directly practical, though weakened by presupposing the reader to be well versed in the various functional tests. This chapter has been wisely prepared in that it ignores that which is not established fact.

The remaining sections are highly technical, and while interesting are incapable of application by the ordinary medical man. Nevertheless, they are useful to him, in that he is capable of obtaining from them a general knowledge of the matter, which will serve him in good stead in determining the necessity of special investigations by the laboratory expert.

**Philadelphia County Homœopathic Medical Society.** The regular monthly meeting of the Philadelphia County Homœopathic Medical Society was held at Hahnemann College on the evening of February 12th, 1920 at 9.00 o'clock.

There were twenty-seven members and one guest present. The meeting was called to order by the president at 9.15 o'clock. The minutes of the previous meeting were read and approved.

In regard to medical legislation Dr. T. H. Carmichael read two letters which showed that the interpretation of the Prohibition Act as effecting physicians is in a chaotic state. One letter from John F. Grammer related to the purchase and use of alcohol by Homœopathic Physicians. Dr. Carmichael also read section 57 of article 60 of the Prohibition Act.

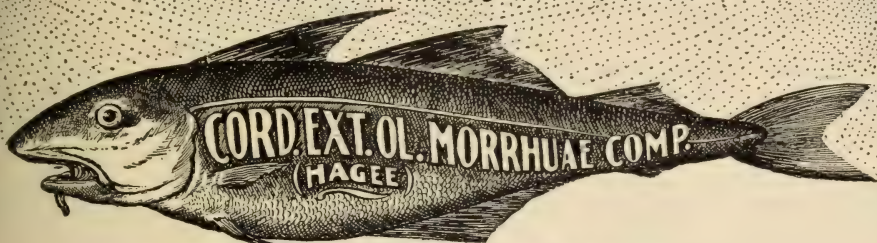
Dr. Theodore J. Gramm thought that in dealing with the government in this matter concerted action should be taken and not approach the government as individuals.

There were no other committee reports.

There was no unfinished business or new business.

## THE LET-DOWN AFTER RESPIRATORY DISEASES

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possesses this power and hence is definitely indicated in convalescence from respiratory infections. Its advantages lie in its potency and palatability.

EACH FLUID OUNCE OF HAGEE'S CORDIAL OF THE EXTRACT OF COD LIVER OIL COMPOUND CONTAINS THE EXTRACT OBTAINABLE FROM ONE-THIRD FLUID OUNCE OF COD LIVER OIL (THE FATTY PORTION BEING ELIMINATED) 6 GRAINS CALCIUM HYDROPHOSPHITE, 3 GRAINS SODIUM HYDROPHOSPHITE, WITH GLYCERIN AND AROMATICS.

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PHYSICIANS and friends desiring to place any aged invalid or mild mental patient in a quiet, select, well-furnished home where they will receive the best of care, will do well to visit this place before deciding elsewhere.

Booklet sent on application.

C. SPENCER KINNEY, M.D.,

(Late First Assistant Physician at the Middletown State Homoeopathic Hospital, New York.)



Dr. L. E. Marter reported a clinical case of a child 13 months old who had swallowed a cent. The X-ray plate showed the foreign body lodged in the narrowest part of the oesophagus. The cent had been in this position for 12 days, and when it was removed by the use of an electrically lighted laryngoscope and long alligator forceps it was found that quite a few inflammatory adhesions had grown up which made it necessary to use considerable traction to remove the cent.

Dr. Ira O. Denman of Toledo, Ohio presented a paper entitled "The Pecuniary Relationship of the Doctor and Patient."

Dr. Mary D. Ridgway of Philadelphia, presented a paper entitled "Medical Economics."

The papers were discussed by Drs. Wells, Carmichael, Gramm, Alexander and MacKenzie.

A vote of thanks was tendered to Dr. Ira O. Denman for his admirable paper.

The meeting adjourned at 11.00 o'clock.

Theodore K. Gramm, Secretary.

**New York Medical College and Hospital for Women.**—At the meeting of the New York State Regents, the question of the revocation of the Charter of the New York Medical College and Hospital for Women was discussed. Dr. Sophie B. Scheel and Dr. Mary A. Brinkman, two loyal alumnae of the College, eloquently pleaded with the Board of Regents not to revoke the Charter but to permit it to remain quiescent with the hope that when financial support was received, the college could again be re-opened.

The request was granted and inasmuch as the profession has been interested in the fate of this Institution this item of news will be welcomed by all well wishers of the Institution.

New York Medical College and Hospital for Women.

By William H. Dieffenbach, MD.,  
President Board of Trustees.

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## DEATHS.

Frank C. Stewart, Indianapolis; Hahnemann Medical College, Chicago, 1886; aged 66; a member of the Medical corps of the Indiana National Guard during the war with Spain; died January 1, from paralysis agitans.

Oscar Wilhelm Carlson, Milwaukee; Hahnemann Medical College, Chicago 1872; aged 76; a practitioner for fifty-four years; a veteran of the Civil War; a member of the staff of St. Mary's Hospital, died January 7th.

Monroe Jacob Holben, Slatington, Pa.; Hahnemann Medical College, Philadelphia, 1875; aged 69, a member of the town council of Slatington; died December 17, from neurasthenia.

Elbridge Olin Kinne, Syracuse, N. Y.; University of Michigan, Ann Arbor, 1878; aged 76; consulting physician to the Homœopathic Hospital; died January fourth, from heart disease.

James E. Morrison, Boulder, Colorado; Hahnemann Medical College,

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influenza and pneumonia) large  
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DR. WM. DEVITT, 130 Green Lane, Manayunk, Pa.

Chicago, 1866; aged 85; for many years a practitioner of Paxton and Urbana, Ill.; died January 1st.

Ralph W. Connell, Omaha; Pulte Medical College 1882; aged 60; formerly health commissioner of Omaha; died January 3, from heart disease.

Frank A. Maguy, Chicago; Hahnemann Medical College Chicago, Ill., 1899; aged 61; died December 29 from bronchial pneumonia.

Frank Duncan, Paxton, Ill.; Hahnemann Medical College, Chicago, 1875; aged 71; died January 1.

Taylor E. Raines, Concordia, Kan.; Hahnemann Medical College, Chicago, Ill.; 1891; aged 67; formerly secretary and president of the State Board of Medical Registration and Examination, and president of the local Board of Health; one of the first officers of Cloud County; died January 12th, from spinal disease.

**Homœopathic Medical Society of the County of New York.**—The regular meeting of the Homœopathic Medical Society of the County of New York was held at the Academy of Medicine, 17 West 43rd St., Thursday, Feb. 12th, 1920, the meeting being called to order at 8.20 P. M., by the President, Dr. J. H. Fobes. Attendance 33. The minutes of the last meeting were read and approved.

On motion of Dr. Von Bonnewitz seconded by Dr. Raynor, it was unanimously voted that the secretary cast the ballot for the election to active membership of the following: Drs. LeRoy Franklin, A. L. Chambers, S. W. Gregory, Alphons Hertel, J. A. McPhillips, Frances W. Morell, E. S. Pope, F. L. Mosser, N. H. Lewis, S. G. Mundell, Moc J. Mayer, George Norton, G. H. Von Gillueve, L. B. Whitman, S. P. Jewett, A. E. Renner, G. H. Taylor, C. B. Reed, W. D. Duckworth, J. C. Haynes, S. C. Roane, W. A. Wilder, Max Greenwald and H. L. Hermes. The secretary announced their election. On motion of Dr. Sprague Carleton, seconded by Dr. Charles Ver Nooy, Dr. Harry Gilbert, 130 West 46th St., was nominated for active membership. On Motion of Dr. W. D. Duckworth, seconded by Dr. G. F. Raynor, Dr. Roy Duckworth of White Plains, N. Y., was nominated for corresponding membership.

Dr. Geo. F. Raynor, chairman of Dinner Committee reported that owing to the weather conditions on the night of the dinner the committee had not been able to dispose of all the tickets they had been compelled to guarantee the hotel authorities, which left them with a deficit of between seventy-five and one-hundred dollars.

On motion of Dr. Dieffenbach, seconded by Dr. Thomas, it was unanimously voted that any deficit be made good out of the current funds of the Society.

The Bureau of Clinical Medicine, Dr. George F. Raynor, chairman, presented an able paper entitled, "Syphilis of the Lung," by Dr. Max Greenwald. Discussion was opened by Drs. W. H. Dieffenbach, J. C. Williams and J. C. Howard. In the general discussion which followed, Drs. Raynor, Carleton and Perkins participated.

The Bureau of Obstetrics, Dr. Philip Cook Thomas, chairman, presented three exceedingly interesting and practical ten minute papers, by Dr. L. S. Loizeaux, "History of Repeated Pregnancies in Double Uterus," Dr. W. G. Grump, "History of Advanced Case of Carcinomatosis Complicated by Pregnancy," and Dr. H. B. Safford, "A Case of Twin Pregnancy, with Rupture of the Uterus, Treated by Hysteriotomy."

In the general discussion which followed, the following members





## **EASE—REST—SLEEP**

When the physician orders Antiphlogistine applied warm and thick over the entire thoracic wall, the pneumonic patient is soon in a restful, natural sleep, which often marks the beginning of convalescence

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relieves the congestion by increasing the superficial circulation. The cutaneous reflexes are stimulated causing contraction of the deep-seated blood vessels, the overworked heart is relieved from excessive blood pressure, pain and dyspnoea are lessened, the elimination of toxins is hastened and the temperature declines.

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took part: Drs. Dieffenbach, Greenwald, Levy, Thomas, Tritsch and Fobes.  
Meeting adjourned at 9.50 P. M.

Charles Ver Nooy, M.D., Secretary.

**Homœopathic Medical Society of the County of New York. Letter to the Profession.**—At the regular monthly meeting of the Homœopathic Medical Society of the County of New York held in the Academy of Medicine, Manhattan, January 8th, 1920, the Chairman of the Legislative Committee, Frederick M. Dearborn, M.D., made the following report and recommendations:

Resolutions Relative to Compulsory Health Insurance offered at the regular monthly meeting of the Homœopathic Medical Society of the County of New York, held in the Academy of Medicine, Manhattan, January 8, 1920.

Whereas: We the members of the Homœopathic Medical Society of the County of New York recognize that it is an important part of our duty as physicians to safeguard the traditions of the science and art of medicine in all its branches, and to promote the efficiency both of the individual practitioner as well as collective scientific endeavor to the end that we may preserve the public health and contribute to the well-being of the citizens of our State and Country, and

Whereas: We feel that the public has a right to expect from the medical societies of this County proof of our confidence and loyalty in them,

Therefore be it Resolved that we, the members of the Homœopathic Medical Society of the County of New York, assembled on January 8, 1920, are uncompromisingly opposed to compulsory health insurance in any form, and that we feel that this legislation is partisan to a great degree, is un-American and unscientific and contains none of the elements of true economics, all of which facts can easily be proven by the operation of similar laws in Great Britain and Germany, and

Be it Further Resolved that we hereby urge the Governor and Members of the Legislature of this State to use their best endeavor to defeat any bill embracing compulsory health insurance, by whomsoever introduced and in whatever form.

On motion of Dr. F. M. Dearborn seconded by Dr. S. B. Moore, it was unanimously voted that these resolutions be adopted by the County Society and the Secretary was instructed to send a copy of the same to the Governor and each Legislator, duly attested by the officials of the Society and bearing the Seal of the same.

Respectfully submitted,

Joseph H. Fobes, M.D., President.

Charles Ver Nooy, M.D., Secretary,

**New York State Society.**—At the dinner of the Society to be held the evening of April 13th at the Hotel Ten Eyck, Albany, Lt.-Col. Theodore Roosevelt has been secured to address the diners. Another speaker will be the Mayor of Albany and Dr. Chas. Sawyer, President of the Institute will complete the program.

The New York State Society has extended an invitation to the Presidents of all eastern State Societies to be the guests of the Society at this dinner. Dr. O. S. Ritch, chairman of the College Committee has announced the title of his five minute discourse at the College Luncheon which will be held at one P. M., the second day of the meeting, April 14th. Dr. Ritch will speak on "Sixty Years Progress of the New York



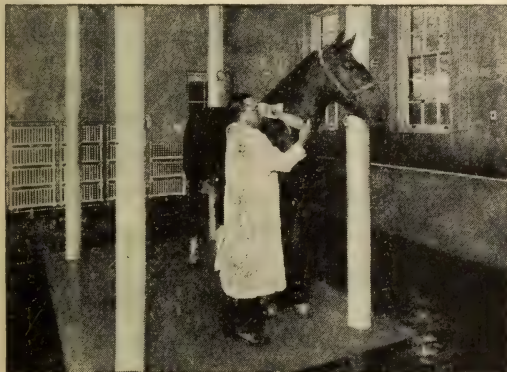
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College, Told in Five Minutes." The speeches at the luncheon will be limited to a five minutes time. Every person in attendance at the meeting is distinctly requested to be present at this luncheon no matter whether he or she may be an Alumnus of the New York Homœopathic Medical College or not.

Gratifying results are being secured by the personal canvass which the Executive Committee is making of all Homœopathic physicians throughout the State to secure their attendance at this meeting. The efforts of the individual member of the Membership Committee have not been up to the standard of the energy displayed in other departments of the State Organization and the president, at this time, desires to again inform the members of this Committee that they have duties to perform which so far they have failed to accomplish.

Dr. B. W. Sherwood has forwarded his program for the Symposium to be handled by the men\*of Syracuse. The profession of Syracuse have combined their efforts and as a result the contribution from the Syracuse men will carry us back to the "Good Old Times of the State Society." The papers are to be limited to seven minutes in length and this one bureau will repay anyone who makes the trip to Albany. The full report of the bureau is as follows: "Thyroid Disease." 1. Introduction and Etiology by Dr. B. W. Sherwood. 2. Symptomology and Diagnosis by Dr. A. A. Getman. 3. Laboratory Findings by Dr. L. S. Henry. 4. Neurological Symptoms by Dr. G. W. Hoyt. 5. Medical Treatment by Dr. R. W. Graham. 6. Homœopathic Remedies by Dr. O. L. Wiley. 7. Surgical Treatment by Dr. J. H. Irish.

The papers for the meeting will be team work papers from the several hospitals throughout the State. The discussers will be drawn from the Staffs of the Metropolitan, Carson C. Peck, Laura Franklin and Rochester Homœopathic Hospitals, which unfortunately this year could not be given a bureau due to the lack of sufficient number of bureaus, but Dr. J. H. Fobes, chairman of the Metropolitan Hospital Staff and Dr. M. T. Hopper, chairman of the Carson C. Peck Hospital Staff assure us that a representative group of eight men from each staff will be present at Albany to represent their institutions and discuss these papers.

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## HAHNEMANN COLLEGE NOTES.

C. R. Hutcheson, Editor-in-Chief.

**Institute Banquet:**—The tenth annual banquet of the Institute of the Hahnemann Medical College was held on the Roof Garden of the New Bingham Hotel on Wednesday evening, February 11th. At least 235 men partook of the festivities of the evening including faculty, alumni, students and numerous guests of the Faculty.

Hahnemann colors very beautifully adorned the entire Roof Garden, together with pennants and banners of various descriptions, and numerous electric displays. The tables were arranged in a most picturesque and striking fashion, so in all, the room presented nothing that could lack a "Real modern Banquet Hall."

Having all assembled in their respective prearranged places, the program for the evening was initiated by the singing of the Hahnemann song in unison.

During the course of the evening several different and pleasant

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Correspondence with physicians is invited and will be welcome as we are anxious to demonstrate our desire to co-operate with them in every possible way.

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selections were rendered by the Hahnemann orchestra under the leadership of Mr. Robert Lehman, and by the Glee Club under the direction of Mr. Harry Mark. These, with the aid of a splendid orchestra engaged for the evening, as well as the singing of the most popular songs in unison, under the leadership of the song leader, permitted no idle moments free from the musical joy.

Much enthusiasm was created by the class songs furnished by the Juniors who seemed to have a most acute sense of humor along this line. Mr. Miller of the Junior class, proved himself very successful as an impersonator of one of the worthy Faculty members in demonstrating a case of Typhoid Fever. Mr. Goekin of the same class, proved himself most efficient in the art of "Hulu dancing."

Dr. William W. Speakman, renowned for his ability as toastmaster, presided in this capacity during the evening, with his usual wit and humor he held the guests at awe and discharged his duties most successfully.

The first speaker called upon was Dr. William A. Pearson, Dean of the Hahnemann Medical College. The Dean responded by saying that Hahnemann was unquestionably the best medical college in the world and that the students were exceptional, being only those of the highest type. He further remarked that it had been the expression of Colonel Lockwood, who having traveled the world over, and having come in close affiliation with the various types of men, that the Hahnemann men were indeed a class for which we can all be proud of. An expression of this character from a man of such repute must indeed convey considerable value. With his further remarks, the Dean spoke of how an appeal had been made to the Board of Trustees for the erection of a new college building, one of the most modern in character, which he had all reason to believe would favorably be considered by the Board, and that in less than two years much progress would be noted in its realization. It was also suggested that a dormitory would be asked for in the very near future as an adjunct to the new college building. With a few more boosts for Hahnemann, the Dean concluded his remarks.

At this time, the monologue artist was introduced who entertained the assembly with his usual wit and humor.

The second speaker of the evening, introduced by the Toastmaster, was Dr. Gilbert Palen. Dr. Palen spoke most profoundly of how Homœopathy today had reached a higher standard than at any other time. He emphasized the fact it was the firm obligation of every Homœopath today to remain staunch with the Homœopathic principles, for it is we ourselves who must make Homœopathy what it is to be in the future. He further spoke of the great interest of the Faculty of Hahnemann for the students, and with a Dean who, working hand in hand with all those things to the furtherance of Homœopathy and Hahnemann, our men cannot but graduate determined that Homœopathy is and shall continue to be paramount in the practice of medicine.

At this time, the versatile musician was introduced who, with his masterly control over so vast a member of musical instruments, furnished much amusement.

Colonel John W. Lockwood was then introduced with very high tribute as the "Real Honor Guest of the evening." Colonel Lockwood who was in command of the Students Army Training Corps at Hahnemann, was much beloved by the students and by all those with whom he became affiliated, and indeed it was a pleasure to have him with us.



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The Colonel was given a rising vote as he took the floor, as a token of appreciation, friendship and deep respect that is felt by the entire Faculty and student body of Hahnemann College.

The Colonel spoke of how he regretted being only privileged to be with the men of Hahnemann for such a short time. He further expressed his hope for the organization of a chapter of the American Legion at Hahnemann in the very near future. With many good wishes for Hahnemann he closed his remarks.

The last speaker for the evening was Mr. Frank Shrenk, a noted lawyer of Philadelphia. Mr. Shrenk expressed his love for Homœopathy and for Hahnemann having always realized the high standard on which Homœopathy has its morals. In his remarks, he spoke of how "Every man a vision, every man worth while" and explained how no matter what the aim or desire, just so long as one keeps his eye steadily fixed on that goal, and with just that degree of effort exerted, just so far will his success be limited along that line.

With the singing of the second Hahnemann song, in unison, composed by Dr. Gilbert Palen, the guests departed well pleased with the success of the occasion.

The great success of the Banquet was largely due to the untiring efforts of the committee in charge, under the careful guidance of Dr. Ralph Bernstein, who has justly been honored with the title of "Expert on Institute Banquets." The committee were as follows: Goeringer, Chr. Hunter, Dickinson, McGarvey.

The entire Institute wish to extend their congratulations and appreciation for their untiring efforts and interest.

**Seniors:**—With a keen eye fixed upon that warm day in June, we strive along toward that ardent goal. While the time seems swiftly fleeing by, yet we all realize that there is a "final conference" which must exact the most careful consideration of each and every man of the class.

Indeed, the Senior class is to be congratulated upon its most wonderful discoveries, as one can judge from the following:

Head in the Medical Clinic:—(Dr. reading history of patient taken by Senior student) Occupation—"Nut Sorter." The gentlemen in the case decided that the patient must sort some kind of "nuts" so they simply added, "In a Fruit Store." It was later learned, however, that the patient worked in a machine shop.

"Nuggets" from Quiz on Gastro-Enterology. Dr. to Senior:—Outline the treatment for acute dilatation of the stomach.

Senior:—Postural Version, Doctor. It can easily be assumed what section the member is in.

One of the members declares that he has often been troubled with colds in the winter because he changed from light to heavy underwear, but now "he wears the same underwear winter and summer and never changes."

**Freshman Notes:**—With the initiation of the second semester, each man has grasped the sword with a new vigor.

To say that all the members of the class are very much pleased with their course in Pharmacy under Dr. Bornemann will suffice. Dr. Bornemann teaches the system of Homœopathic drugs from the time of beginning growth of the plant in the soil until the drug is worked up for practical Homœopathic application.

We still find ourselves plodding along with our course in Anatomy

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By A. EVERETT AUSTIN, M.D., A.M., former Professor of Physiological Chemistry at Tufts College, University of Virginia, and University of Texas; Present Assistant Professor of Clinical Medicine, in charge of Dietetics and Gastro-Intestinal Diseases, Tufts College. 552 pp., 85 original illustrations, 10 colored plates. Cloth .....\$5.50

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under the careful guidance of Dr. Sylvis. One point emphasized most profoundly in one of the lectures was where Dr. Sylvis said, "Did you ever realize that the smile was only given to the human being?" And indeed it is true, especially with the physician, whose very presence should vanish the sorrow that often broods over the sick-room.

The question has been asked "Where are the landmarks of the body?" Wonder who knows.

At last we have our desires fulfilled by being ushered under the care of Dr. Rufus B. Weaver, for dissection of the cadaver. No one has ever affiliated himself with Dr. Weaver who has not been charmed by his sterling quality, marked ability, and his endless love for the student. Indeed it is certainly a pleasure to be in his company, and we certainly anticipate a most instructive and enjoyable course.

As all science has a beginning we must naturally turn our attention to the principles of Homœopathy. To say that Dr. Bernstein is master of the subject will suffice, so much so, that we feel as real lawyers to argue for Homœopathy.

**Second Year Science:**—We have met the enemy and they are ours. At least we hope so. We refer to our mid-years of course.

We welcome back to our midst our friend and classmate Harold Guyler who spent a week in the hospital. At the same time, we are sorry to note that his bed has been immediately occupied by Earl Conlin. We wonder who will be next?

**First Year Science:**—Glancing back over the many events that have crowded themselves upon our class since the return to duty following the holiday vacation, we find very little that may interest our friends. We have found ourselves so absorbed in our endeavors with passing off our numerous examinations that very little time has been afforded for indulging in the humorous side of life.

We were all pleased with the introduction of Anatomy to our roster beginning with the Second Semester. While we realize that anatomy is a very vast subject, yet we know that our course shall be most enjoyable and instructive under the able direction and super ability of our present professor.

Seems to be more wills to probate. "Bob" Stroh has been called home.

It is with much regret that we learn that several of our members have fallen victims of the "Flu" and thus wish to extend our sympathies to Treasurer "Sommers", Ralph Appleton and Bill McCoy.

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**Physician Wanted.**—Man or woman, with Homœopathic training, for the position of Assistant Physician in a State Hospital of 1,300 beds. Interesting work, pleasant surroundings, and opportunity for advancement. Address Walter E. Lang, M.D., Superintendent, Westborough State Hospital, Westborough, Mass.

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Vol. 1

DECEMBER, 1919

No. 2

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\* *Journal of The American Medical Association* 599-601, Aug. 23, 1919.





## PERSONALS.

Dr. J. Herbert Moore announces the removal of his office and residence to 29 Williston Road, Brookline, second house on right from Beacon Street, opposite the white-post-stop of "Williston Road and Tappan Street" of the Beacon Street car line.

Dr. John Newton Goode of 59 Riverside Drive, Saranac Lake, N. Y., announces that having located there he is giving special attention to tubercular conditions of the throat and lungs and with especial reference to the application of Homœopathic therapeutics, also diet, hygiene and rest or minimum exercise. Hours 12 to 2 and by appointment.

Otto James Blessin, Galesburg, Ill.; Hahnemann Medical College, Chicago, 1901; aged 40; Captain, M. R. C., U. S. Army and discharged, Jan. 18, 1919, died Jan. 29th.

Charles Ash Bower, Mitchell, S.D.; Hahnemann Medical College, Chicago, 1900; aged 44; was drowned while bathing at Lake Worth, Fla., January 21st.

**A Most Excellent Example for All Societies to Follow.**—Dr. Wm. Raymer of Beaver Falls, Pa., writes that the Beaver County Homœopathic Physicians are 100 per cent. members of the County, State and National organizations. It looks very much as though any physician settling in Beaver County was told his duty by Dr. Raymer.

**Homœopathic Medical Society of Pennsylvania.**—The next annual meeting of this society will be held at Harrisburg, Pa., beginning on the 21st of September and closing on the 23rd. The President, Dr. R. L. Piper, of Tyrone, is now active in preparing his plans for the occasion. The various bureaus and committees will be announced in our next issue.

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# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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APRIL, 1920

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**Nervous and Mental Diseases.** By Archibald Church, M.D., Professor of Nervous and Mental Diseases in Northwestern University Medical School, Chicago, and Frederick Peterson, M.D., formerly Professor of Psychiatry, Columbia University. Ninth edition, revised. Octavo volume of 949 pages, with 350 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$7.50 net.

Very few medical works are accorded the compliment of a ninth edition. In the preparation of this edition no radical changes have been made. Guided by the kindly advice of a large number of medical teachers, the same general presentation of neurological subjects has been retained. Some radical views which have attained considerable popularity have not been incorporated, more time and experience being thought requisite for their unquestioned establishment.

The subjects of General Paresis and Traumatic Insanity have been rewritten and many interpolations and minor corrections made. The needs of the student and the wants of the practitioner have been first consideration throughout.

The continued demand for the book is a great gratification to the authors.

**Homœopathic Medical Society of Chester, Delaware and Montgomery Counties.**—The regular meeting of the Tri-County Medical Society of Chester, Delaware and Montgomery Counties, was held at the University Club in Philadelphia, Tuesday, December 9th, 1919, at 1 P. M. The new

president, Dr. J. Oscar Dicks of West Chester, presided. The following were elected active members: Dr. Paul Atkinson, Dr. H. S. McKinstry, Dr. C. A. Rowland. The following names were proposed for active membership, Dr. James Shoemaker, Dr. Harold Kistler, Dr. William Dunlap and Dr. C. D. Fox.

Dr. A. B. Webster read an excellent paper on "Infections of the Biliary Tract," which was followed by an interesting and lengthy discussion by Drs. G. A. Van Lennep and W. Williams. The second paper of the day was read by Dr. Sigmund Raue on Metabolism and Nutrition in Infancy," which was followed by an interesting discussion.

Meeting adjourned to meet again on the second Tuesday in February at the University Club, Philadelphia, Pa.

F. T. Krusen, M.D., Secretary.

**The Clinico-Pathologic Society of Philadelphia.**—The regular meeting of the Clinico-Pathologic Society was held in the Hahenmann Hospital, Thursday evening, February 5, 1920, at 8.30 o'clock. The following papers were presented: (1) The Surgical Risk from a Modern Standpoint, D. Roman, M.D. Discussion opened by Dr. H. L. Northrup. (2) The Responsibility of the Physician in the Prevention of Dull Hearing, Gilbert J. Palen, M.D. (3) The Treatment of Dull Hearing the Result of Affections of the Upper Respiratory Tract, Joseph V. F. Clay, M.D.

Joseph V. F. Clay, M.D., Secretary.

**Homœopathic Medical Society of Germantown.**—The regular meeting of the Germantown Homœopathic Medical Society was held at Hahnemann Medical College on the evening of February 16, the president, Dr. O. S. Haines, in the chair. Drs. L. E. Marter, Frank P. Stone, Francis H. Murray and G. Morris Golden were elected to active membership.

The paper of the evening was presented by Dr. J. E. James, and was entitled a "Resume of Puerperal States." It was discussed by Drs. Lane, Tomlinson and Hopp.

The old gavel, properly mounted and inscribed was presented to the retiring president, Dr. Ernest L. Clarke.

A motion to amend the by-laws as follows was made: Article 10, section 3 to be changed so as to read as follows: "The entertainment board shall provide entertainment for each meeting, provide the place of meeting, the menu and for each monthly meeting an address or paper for discussion on some medical subject; and may draw an amount equal to one twelfth of the yearly dues to be accumulated to the credit of the entertainment board, such amount, however, to remain with the treasurer till needed; furthermore by a majority vote of the members present at any meeting, an extra amount of money may be allotted for the use of the entertainment board."

**Homœopathic Medical Society of Philadelphia County.**—The regular monthly meeting of the Philadelphia County Homœopathic Medical Society was held at Hahnemann Medical College, Thursday evening, March 11, 1920.

There were thirty-five members present.

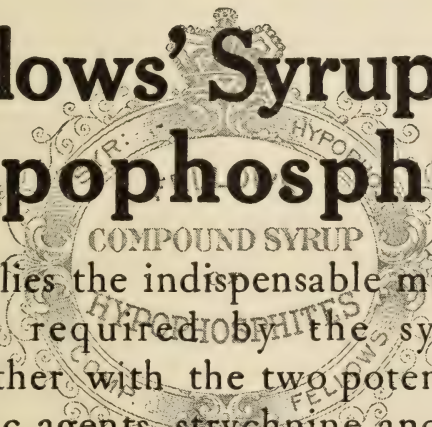
The meeting was called to order by the president, Dr. G. W. MacKenzie at nine o'clock.

The minutes of the previous meeting were approved as read.

There were no committee reports.

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very frequent sequel of  
Influenza.

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SAMPLES AND LITERATURE UPON REQUEST

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No report of the censors.

No unfinished business.

No new business.

Dr. John A. Brooke presented a clinical case of Poliomyelitis Anterior in which there was a paralysis of the shoulder muscles of the right arm. The chief point to be remembered in connection with other treatment is to remove the strain from the paralyzed muscles by the use of a brace of the abduction type.

Dr. H. L. Northrop showed a tuberculous right kidney removed from a boy sixteen years old. The first symptoms noticed in this case were frequent micturition, polyuria, cough and loss in weight.

Dr. W. C. Hunsicker made a cystoscopic examination and found tuberculosis in the right half of the bladder.

Dr. G. Harlan Wells said that no tubercle bacilli were found in the urine examination, and that the physical signs in the lungs were few.

Dr. J. W. Frank showed the X-ray plates of the lungs. A miliary tuberculosis was present in the right lung.

Dr. H. P. Leopold showed a round cell sarcoma of the thigh removed from a woman 60 years old.

The first essay was presented by Dr. H. P. Leopold entitled Diagnosis of Diseases of the Gall Bladder.

Dr. G. A. Van Lennep presented the second essay entitled Surgical Treatment of Diseases of the Gall Bladder.

The papers were discussed together by Doctors H. L. Northrop, D. Roman and A. B. Webster.

The meeting adjourned at 10.40 P. M.

Theodore K. Gramm, M.D., Secretary.

**Homœopathic Medical Society of the County of New York.**—The regular meeting of the Homœopathic Medical Society of the County of New York was held at the Academy of Medicine, 17 West 43rd St., Thursday, March 11, 1920, the meeting being called to order at 8:16 P. M. by the President Dr. J. H. Fobes. Attendance 42.

The minutes of the last meeting were read and approved.

On motion regularly seconded and unanimously carried the Secretary was requested to cast the ballot for the election to Corresponding Membership of Dr. Roy D. Duckworth of White Plains, N. Y. The secretary announced his election.

The President announced the death of Dr. E. G. Tuttle, and appointed Drs. Geo. W. McDowell and Geo. A. Shepard a Memorial Committee, to report at the next meeting of the Society, April 8, 1920.

The President read a very interesting and informative letter from Dr. R. F. Rabe, acting Dean of the New York Homœopathic Medical College and Flower Hospital, and said it is the aim of the "Executive Committee" to have a monthly report presented at the meeting of the Society, giving an account of the "State of the College."

The Bureau of Pediatrics, Grace M. Kahrs, M.D. chairman, presented a paper entitled "Some New Points in the Diagnosis and Treatment of the Diseases of the Endocrine Glands, with Special Reference to Children," by William N. Berkeley, M.D. This able, practical and scientific paper, the result of clinical work and exhaustive laboratory endeavor, was most cordially received. The discussion was opened by Drs. Klots, Thomas and Benson, while Dr. Harrington spoke in the general discussion which followed. All of the discussions spoke very highly of

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(Late First Assistant Physician at the Middletown State Homoeopathic Hospital, New York.)

the subject matter presented in the paper, of the importance of a more extended study of these glandular structures, and were grateful that they had been privileged to hear the matter presented by one who could speak from actual clinical experience and not from theory.

On motion regularly seconded and unanimously carried, a vote of thanks was tendered Dr. Berkeley for his scientific and scholarly paper.

The Bureau of Surgery and Gynecology, M. W. McDuffie, M.D., chairman, presented a paper entitled "Uninary Stones" by Louis Rene Kaufman, M.D. This decidedly interesting, practical and difficult subject was very skillfully presented by Dr. Kaufman and a large number of cases were reported, many of which were illustrated by the stereoptican. The discussion on this paper was general; the following participated therein: Drs. G. F. Laidlaw, Sprague Carleton, C. W. Perkins, B. G. Clark, E. L. Burwell and C. H. Wintsch.

Meeting adjourned at 10:20 P. M.

Charles Ver Nooy, M.D., Secretary.

**New York State Homœopathic Medical Society.**—The Committee of Local Arrangements report among the speakers for the dinner, Mayor James R. Watt of Albany, who will make the opening address and the Rev. J. V. Moldenhawer, pastor of the Westminster Presbyterian Church of Albany, will also make an address at the dinner. Dr. R. F. Rabe, the acting Dean of the New York College, has been added to the speakers at the Alumni Luncheon.

The program of contributions from the Albany Homœopathic Hospital has been received. Dr. J. I. Dowling will present a paper entitled "Ligation of the External Carotid Artery for Certain Disease of the Eye and Ear," and will exhibit two cases. Dr. B. E. Kinne will present a paper on "Hospital Standardization" as worked out at the Albany Homœopathic Hospital. Dr. Kinne is also chairman of the Exhibits Committee and reports at the present time that he has secured ten exhibitors.

The meeting will open promptly at twelve o'clock Tuesday, April 13th, and it is distinctly urged that all the members be present for the opening session as at this meeting there will be many topics of interest you should hear discussed and the advice of all members of the organization is needed. Federation with the American Institute, Protective Insurance against Mal-practice Suits instituted against members and the launching of a new journal to carry the transactions as well as news items of the organization are three strong business items.

The President has invited each one of the Presidents of the Eastern Homœopathic State Organization to be the guests of the Society and it is hoped that many of them will avail themselves of the opportunity to be present as the dinner is to be given in their honor.

Dr. B. H. Garrison, President of the New Jersey State Society has already signified his intention to be present and favorable responses have been received from several others. The Massachusetts Homœopathic Medical Society is holding its meeting at the same time and Dr. Lee, the President, therefore expressed regret at not being able to attend.

Dr. S. Carleton has a copy of the new Constitution and By-Laws ready to submit to the Executive Committee and from reading it carefully one can realize that it should aid greatly in increasing the efficiency of the organization.

Roy Upham, M.D., President.



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**HAHNEMANN COLLEGE NOTES.****Chas. R. Hutcheson, Editor-in-chief.**

**Seniors:**—With the sections changed for the last time and as Dr. Rufus B. Weaver expresses it "With the end of the tunnel in view," we will soon bid adieu to college days. We are sorry to see the end come and yet we are all anxious to launch out and do our bit, ever realizing that the call for good Homœopaths becomes more urgent each day. Thus we stand ready to defend our alma mater and to take up the paramount duty of the physician which Hahnemann expresses in the "Organon" as that of "Curing the Sick" or, as has been frequently expressed in the clinic "make sick people well."

The clinics at the Municipal Hospital have proven invaluable—Scarlet Fever and Diphtheria as the subjects under discussion have been very thoroughly exhausted and that most valuable instruction has been obtained cannot be questioned.

Appointments have been made to the various hospitals as follows: Women's Homœopathic Hospital, Phila., Pa.: Gingrick, Huturck, Pcholtes, Woodland; Hahnemann Hospital, Scranton, Pa.: Goehringer, Wertz, H. C. Stevenson; Metropolitan Hospital, New York: Chesboro, De Feo, Hawn, Walter; West Jersey Homœopathic Hospital, Camden, N. J.; Hutcheson, Tuly; Massachusetts Homœopathic Hospital, Boston, Mass.; Thompson, Walker; National Homœopathic Hospital, Washington, D. C.; Scruggs.

There is always more than one way to get a bouquet of flowers. This was manifested in the medical ward at a recent date, when one of the worthy seniors, having heard that flowers were about to be distributed among the patients, donned a night robe and casually sat in a chair by the bed-side. As a consequence he received his allotted portion. The distributor evidently inferred that the patient was well on the road to recovery and would soon be able to leave the hospital.

**Juniors:**—Again we are on the job. Easter vacation past, and finals already looming high above our horizon. We have found the year as a whole very instructive but rather difficult and it has occasioned much burning of the "midnight oil."

Quoting from the previous issue in reference to the Institute Banquet: "Much enthusiasm was created by the class songs furnished by the Juniors." Leave it to the class of 1921 to get away with it.

Charlie Kutteroff and Fred Abbott have quite suddenly assumed the unique position of class freaks. Both are authentically known to have acquired several accessory fingers in one morning.

O. Ziegler, our class poet and the author of "Languid Lives," has announced that his latest book "Drowsy Ditties" will soon be ready for publication.

**Sophomores:**—Our new schedule of work is proving most interesting for we are just beginning to become acquainted with those subjects generally associated with medicine.

We were all much awed in looking over our schedule to find listed, Pharmacodynamics: and it is needless to say that many had their visions. But after one lecture with Dr. Haines, much enthusiasm and interest has been created. There have always been a few skeptics con-

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cerning Homœopathy among the men, but after completing this course there is no doubt that we will all be "Seniore Pures."

In physical diagnosis we are learning lots of things—strange and new. Among them is Littens phenomenon, concerning which we have an entirely new version—ask Burns. It might be well to add in passing that it took one of the men five weeks before he could pick up courage to come to class for fear of having to strip; and we were wondering at this rate when he would have put in his appearance if we had co-education—just to think of it—terrible, terrible.

Bandaging proves most interesting, and as expressed by one of the men that considering he had been in college for four years (another phenomenon) it was about time he learned to do something practical.

The doctor of today must be a practical philanthropist whose duty lies in doing the people good. With this thought in mind we will ever strive to "do 'em good."

**Freshmen:**—Our class has been very fortunate in having Dr. Steinhilber return to teach "Neuro-Histology." We know from the past that his ability as a teacher and his interest manifested in the student cannot be surpassed and we feel confident that our course will be most pleasing and instructive.

We regret that Richardson has been compelled to discontinue his work with us this term, on account of conditions growing out of his army service. We hope however that he will be able to return with us again in the fall.

Through the kindness of Mrs. Evans, the College Librarian, several members of the class have been honored as guests at the home of Mr. Walter E. Hering. Mr. Hering has always been a most sincere friend of the student and indeed it has been a pleasure to associate with a man who has the interests of our college as well as that of Homœopathy so dear to his heart. We are all very grateful for his kindness and take this occasion as a means of expressing our appreciation.

**Second Year Science:**—Ted Geary—yes, Minersville is listed among Pennsylvania's leading towns. The manager of the shoe factory there has to hire a helper to assist him in his business.

We extend a hearty welcome to Gus Wright and Joe Coalin who have just recently recovered from an attack of illness.

**First Year Science:**—Let us introduce our two new members of the class "Lydia Pinkham" and "Father John." "Lydia" comes from Warren, Pa. and "Father John" comes from Bristol. However, they say they're old friends.

Marsh has been knocking down precipitates in the chemistry laboratory in great form for the last few weeks.

Again we congratulate Claire Thomas on his recovery. We are informed that he has returned home for a recuperative period, after which he will again resume his studies.

Everybody enjoyed themselves at our Smoker which was held recently in honor of ourselves. This shows we have a real Entertainment Committee.

Much interest has been shown among the members of the class as factors of the drug proving squad. Many have experienced marked symptoms, one prover in particular. This gentleman, acting as a control, was given Placebo. After taking a few doses, he became violently ill, with marked vomiting, severe intestinal crises, and with other concomitant

# Hay Fever Time

1920 JUNE 1920						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	

1920 MAY 1920						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

1920 JULY 1920						
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18	19	20	21	22	23	24
25	26	27	28	29	30	31

1920 AUGUST 1920						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7

1920 SEPTEMBER 1920						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
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5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		



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symptoms, so much so that he deemed it advisable to consult a physician, which he did. The doctor in question, being one of the other school, with a most dignified air, smelling the medicine, remarks as follows: "You have been proving a poisonous drug. I would advise its discontinuance at once." The young prover, from all reports, has unquestionably accepted the advice, as his appearance at the meeting of the provers has been sadly missed since that time.

**The Clinico-Pathologic Society.**—The regular monthly meeting was held in the Hahnemann Medical College, Thursday evening, March 4th, at 9 o'clock. In the absence of the President and Vice-President, Ex-President Dr. S. W. Sappington presided.

Dr. Benjamin Fletcher presented a case of enlargement of all the salivary glands following an acute cold.

Dr. D. Roman presented a scholarly paper entitled "The Surgical Risk from Modern Standpoint." The discussion was opened by Prof. H. L. Northrop. Dr. Roman brought out the advances made in surgery and the minimizing the risk in the evidence of modern methods. Dr. Northrop emphasized the points brought out by Dr. Roman and great stress was laid upon psychology in the practice of surgery. Dr. Palen further discussed the subject laying special stress upon the responsibility of the anaesthetist in surgical practice. Dr. F. O. Nagle gave a short talk upon the occurrence of glaucoma in myopic patients. Discussion by Drs. Palen and Mackenzie.

Dr. Gilbert J. Palen read a paper entitled "The Responsibility of the Physician in the Prevention of Dull Hearing."

Dr. Joseph V. F. Clay read a short paper outlining the Treatment of Dull Hearing the Result of Affections of the Upper Respiratory Tract.

These papers were discussed by Drs. Mackenzie and Alexander. The meeting adjourned at 11 P. M.

Joseph V. F. Clay, Secretary.

**The Essex County Homœopathic Medical Society.**—The regular monthly meeting of the Essex County Homœopathic Medical Society was held Friday evening, February 20, at the home of Dr. Sara D. Smalley, 430 Clifton Ave., Newark. Dr. George F. Laidlaw, 58 W. 53rd St., New York City, presented a paper entitled "The Electro-cardiograph: Its Use and Limitations."

#### DEATHS.

William Frank Kistler, graduate of Hahnemann College, 1874, died at his winter home in St. Petersburg, Fla., on January 30th, from cerebral hemorrhage.

Arthur G. Thome, graduate of Chicago Homœopathic Medical College, 1883, died in the Chicago Union Hospital, Feb. 17th, from heart disease.

George Levi Alexander, graduate Hahnemann Medical College, Chicago, 1888, died on February 13, from cerebral hemorrhage at the age of 54.

Irvine Ketcheson Mott, graduate of Pulte Medical College, Cincinnati, 1883, died in Covington, Ky., February 7th, from cerebral hemorrhage at the age of 59.

Andrew B. Spinney, graduate of Homœopathic Hospital College, Cleveland, 1859, died February 7th, at the age of 84.



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**Report on Annual Congress on Medical Education Held in Chicago, February 29th to March 3rd, 1920.**—At one o'clock Sunday, Feb. 29th, a dinner was tendered all Homœopathic delegates to the Congress. About fifty Homœopathic physicians, who are members of various State Boards of Medical Examiners, representatives of Colleges, Officers of The American Institute and State Homœopathic Societies, were present.

Dr. Metzger of Pittsburgh presented the subject, "Observations of Five Years Activity of the Intern-Training Law in Pennsylvania." After reviewing the State law he explained the system used for classifying hospitals. He said that the kind of hospital records indicated largely the character of work being done and that the establishment of Obstetrical Dispensaries had eliminated about half of the work formerly done by midwives.

Dr. Strickler made a plea for better hospital records and the proper teaching of interns.

Dr. Eastman, who is President of the Minnesota State Board, stated that our hospitals needed more Homœopathy and no proprietary medicines and compound tablets.

Dr. Hodgdon, President of Hahnemann College of Chicago, spoke on the subject "Homœopathy and Present Day Science" and made a strong plea for the necessity of demonstrating our conviction by modern day scientific methods.

Dr. Pearson, presented The American Institute with two pictures from Dr. Joseph C. Guernsey. One, a picture of Dr. Constantine Hering, the other a picture of the home of Samuel Hahnemann, and suggested some methods of advancing Homœopathy.

Dr. Burrett, Dean of Homœopathic Department of the Ohio State University, said that premedical work at Ohio State University was especially adapted to the medical work to follow.

Dr. Dewey read part of an article on "The Treatment of Influenza," published in the March number of The British Medical Journal by Captain Blanchard, enumerating experiments made by Allopathic physicians with eight different drugs. Of the drugs tried only Gelsemium produced marked beneficial results, although Belladonna produced some improvements.

Dr. Hanks stated that the last issue of the Journal of American Medical Association contains an article by Dr. Irons showing valuable results from the use of Homœopathic drugs.

Dr. Roston said that there was no fault with Homœopathy but the fault lay with the people who represented it.

Dr. Sawyer, President of the American Institute of Homœopathy, told of the work being done by The American Institute in Virginia. He said that the Virginia Board of Medical Examiners had denied a graduate of Hahnemann of Chicago the privilege of taking the examinations for licensure and a bill had been introduced in the Virginia Legislature to compel just action.

1862 Homœopathic physicians were in the military service and endorsement of Homœopathic physicians by The American Institute of Homœopathy is very valuable. Dr. Pearson was elected President of The College Alliance.

On Monday morning, Dr. Bevan, Chairman of the Council on Medical Education, gave a review of the work that has been done in the last 16 years and showed that the ideal standard suggested 16 years ago had now been reached.

The new Council on Hospitals was welcomed as a part of the Medical

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Congress and the hope expressed that this Council would bring about as marked improvement in the hospitals as the Council on Medical Education had in medical education. A careful study of all hospitals will be made and definite standards set.

Dr. Bevan stated that the age of the average medical graduate is now 28½ years while in Europe it is only 25. He said the trouble is with the high school. He advocated increasing fees charged to medical students because the cost of educating medical students is much greater than students fees. Hospitals should not charge colleges for hospital instruction. He said that laboratory subjects are not taught well enough from the clinical standpoint and considered that medical students needed more instruction in human Anatomy.

A medical school is a school of Medicine for the purpose of training practicing physicians not a Scientific School. He suggested all time teachers for clinical subjects with privileges of spending a few hours each day in private practice.

Dr. Colwell presented an exhaustive report on "The Present Status of Medical Education." He advocated college training for pre-medical work of such a character that students who find that they are not properly fitted for medicine can advantageously continue their college training and become lawyers, engineers or prepare for any other vocation.

He advised University work as the proper courses preparatory to medicine because of social life, athletics and as a "Safeguard against unscientific cults."

This year there are about 15,600 medical students in the United States and the present A Class Colleges can properly accommodate 15,430. There is one physician in the United States to every 720 population and in England 1 to 1,500 population. The apparent scarcity of physicians is largely due to the fact that physicians congregate in cities.

9,000 interns are now needed for the hospitals of the United States and this demand can be filled in several ways; by increasing the length of intern service, by training nurses and orderlies to do part of work now done by physicians or by employment of stenographers to relieve doctors of clerical work.

Dr. Colwell spoke of "The Underworld of Education" as the Institutions which are improperly giving instruction.

Dr. George Vincent, President of The Rockefeller Foundation, spoke on "The Needs of Medical Education."

Ideals in medical education cannot be generally realized under the many different conditions in this country. The same standard for all is impossible at the present time. Southern high schools and colleges have tried to come up to higher standards and have often lengthened their courses without increasing the number of their teachers or equipment. He advocated saving two years in high school. Limitation of students invaluable and suggested the introduction of certain subjects having a medical relation such as History of Medicine in the pre-medical courses.

Dr. Wilbur, President of Leland Stanford University, advocated thorough training in science in laboratories.

The best clinicians are developed by teaching and for this reason students are just as important to the clinician as the clinician is to the students.

President Twing of Western Reserve University, said that Education is simply power to think and that medical education consists simply in power to think in medical terms. To think is not simply to know but

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to relate. He stated that physicians are too old when they graduate and he also placed the blame on the high schools and grammar schools. Better teaching and smaller classes needed; also more money for education. Graduates of medical colleges should return often for graduate work.

Admiral Braisted told of the organization of Naval Hospitals and suggested that the elements of biology and other Sciences could easily be taught to children.

Surgeon General Ireland said that medical officers entered the Army at the average age of 28.52 years. Line officers are frequently only 23 and the only way to compensate medical officers for longer training is by giving them advanced work which, of course, is very objectionable to the line officers.

At the present time there are 1,400 men in the medical corps and 26,000 patients of which about 10,000 are overseas patients. Expect to retain 1,000 in medical corps and move Army Medical College and Surgeon General's office near Walter Reed Hospital.

The Medical Reserve Corps is to be kept alive with short training camps each year.

Need more young medical officers and will take direct after graduation from college and give good hospital training.

Dr. Jessup, President of Iowa State University, told of the splendid law in Iowa to take proper care of indigent sick. Cases may be reported to District Judge by any physician, nurse, policemen or minister.

Dr. Darrach, Dean of Columbia University College of Physicians and Surgeons, advocated full time teachers for clinical subjects with the best plan of allowing these full time teachers a limited time each day for their own private patients.

Dr. Klotz, Professor of Pathology, University of Pittsburgh, said the outlook for Medical Research in America is very encouraging. Selected men with especial training should devote their whole time to this work. Combined effort by all research workers in a Medical College brings best results. Study questions which lie at doors.

Dr. Robinson, Dean, Washington University, advocated full time clinical teachers who do not have any consultant work.

Dr. Abraham Flexner called attention to the problems of finance. The practical question is how to secure funds to provide for idealistic plans. The American Medical Association has not pointed out any way of financing the recommendations it made. When A. M. A. recommended University affiliations for medical schools the medical schools were anxious to be taken over by Universities, sometimes later to regret of Universities. All medical colleges do not need to be of one type. Impossible to have universal education system. There is needed a very considerable variety of medical schools. He suggested that State Legislatures might take the problem in charge and provide for much lower standards than at present.

Full time clinical teachers is not possible in America. Premature movement for plan. Need tact and good judgment. No plea was made "For anything worse than it has to be" but if a school of medicine is a part of a University it must take its chances with other departments of the same University and on the same basis. Trustees and Presidents must treat all departments the same. The School of Medicine cannot have all of the advantages and none of the disadvantages.

General University status of medical schools far from ideal.



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It takes fortitude to devote life as teacher in University but no more for Pathologist or Surgeon in medical department than a teacher of Latin, or Science in some other. Cannot treat clinical teachers in Medical Faculty as a separate race of supermen. These men must be willing to work on the same modest salaries as teachers in other departments of University.

Dr. Billings said that he had taught in a medical college for nearly forty years and never had a salary till he entered the Army.

In 1900, the total endowment for medical research in the United States was only \$1,000,000.00 now it is about \$100,000,000.00. If such great strides were made in last 20 years what can be done in the next 20?

Teaching of Pathology should be under same roof as hospital.

Dr. Williams, Dean of Medical Department Johns Hopkins, advocated full time plan with privileges for these men to take a limited number of private patients.

Whole time plan expensive and should not be tried by all medical colleges until tried and proven by a dozen of them.

Tuesday morning, Dr. David Strickler, President of the Federation of State Medical Boards, presented a splendid practical paper on "Co-ordination of Effort in Medical Licensure." He recommended similar laws for all states and suggested that representatives of all concerned be called to help formulate a single board for all who treat the sick. Any good man should be able to obtain a license to practice in any state but each state must legally determine value of all credentials. A more tolerant attitude for all must be fostered and wide publicity carried out to show the public the importance of properly trained physicians to protect public health.

Dr. Wilson, Director of the Mayo Foundation for Medical Education and Research, presented a report on Post-graduate education in the United States. He said there are 18 graduate medical schools in the United States but the widest diversity existed in the character of instruction. On the whole it is inadequate and very imperfect. Very interesting data were presented in regard to the post-graduate training of American Medical Specialists. Great variation exists in the opinions of eminent specialists in regard to what post-graduate work should consist of. There is a strong tendency of Surgeons to advise more Pathology and Internists to advise more Physiology and Bio-Chemistry. There are needed now accommodations for at least 6,000 post-graduate students in the United States.

Dr. Bierring, who was Chairman of a Committee which went to England and France to study medical education in these countries and attempt to obtain better medical relations with these countries, presented a comprehensive report. Detailed information was given in regard to methods of Licensing physicians in these countries. At least three separate examinations must be taken in England but graduates of accredited French Medical Schools are permitted to practice without further examinations.

A Committee of English and French physicians will visit the United States this spring for the purpose of studying medical education in this country and it is hoped that some plan will be agreed upon for reciprocity.

Director Shepardson of The Department of Education in Illinois, told of the numerous difficulties his department is having.

Dr. Meeker told of the work being done by The University of Pennsylvania in establishing the Post-Graduate School of Medicine.



Two and one-half million dollars are invested and \$150,000.00 have been expended for equipment. Expect to spend \$200,000.00 per year on post-graduate medical instruction.

Dr. John Roberts of Philadelphia stated that Pennsylvania State Law does not specify that internship must be taken in Pennsylvania.

Tuesday afternoon a symposium was held on methods of teaching various subjects in medical colleges.

Dr. Bardeen, Dean of the University of Wisconsin, outlined his methods used for teaching Anatomy. He said that the criticisms of Pathologists in regard to the teaching of Anatomy were valueless as Pathologists do not know normal Anatomy.

*(To be Continued)*

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# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

MAY, 1920

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**Modern Surgery, General and Operative.** By John Chalmers Da Costa, M.D., LL.D., F.A.C.S. Eighth Edition. Philadelphia and London, W. B. Saunders Co., 1919. 1697 pages, 1177 Illustrations. 8vo. Cloth, \$8.00.

Five years have now passed by since the last edition of this valuable work on surgery by the talented teacher of Jefferson Medical College was published. Seldom indeed does a work of like character receive the compliment of eight editions. For twenty-five years it has ranked among the first of single volume text-books on surgery. With this record back of it we see no reason why the author in his preface should start with the quotation, "Drat him if he aint come back again." All of us will be glad to have Dr. Da Costa come again and again, and trust that his time will be extended to the one hundred and twenty years allotted by the devotees of bulgaria bacillis diet.

The present volume is larger than its predecessor by one hundred pages and one hundred illustrations. The text has been very largely re-written. Special chapters which will interest the general practitioner who does not care to buy monographs on the subjects are those on Bronchoscopy and Esophagoscopy by Dr. Chevalier Jackson, Blood Transfusion by Dr. George M. Dorrance, Orthopedic Surgery by Dr. J. T. Rugh, Barany Test by Dr. S. MacCuen Smith, and X-Ray, by Dr. G. E. Pfahler.

**Report on Annual Congress on Medical Education Held in Chicago, February 29th to March 3rd, 1920.**—(Continued from page 47.)

Dr. Waite of Western Reserve University, stated that 180 to 190 hours were absolutely necessary to properly teach Histology and Embryology and that Embryology should be given as a separate course after Histology.

Weekly quizzes and several written tests were advised with frequent

grading of note books. Students should be asked if teachers are making subjects clear to them. Normal Human Anatomical material is hard to obtain and for this reason the lower animals should be killed to show the normal appearance of organs. Must get students interested. Students should be shown that facts presented have some practical value.

Teach students the language of medicine and insist that they use it. Teach students how to study. Require drawing as a premedical subject. Have students demonstrate lantern slides to class.

Dr. Lyon, Dean of University of Minnesota School, stated that the subject of Physiology needed at least 280 hours for proper presentation. Physiology is most important subject in medical course and the Physiologist is a superman. He advised demonstrations of facts but not to shoot at a flock of facts and hit nothing definite. Get students to use library, stand by fundamental principles and omit most details. Howell thinks that more time should be devoted to Nutrition. Physiology is not a mass of facts but a mode of thought.

Dr. Folin of Harvard stated that Physiological Chemistry is an advanced subject to begin with and that the minimum preparation required for this course is insufficient. Before Biological Chemistry can be properly studied good courses in Organic Chemistry, Physical Chemistry, Quantitative Chemistry are necessary.

In medical schools two weeks need be spent on the fundamentals of volumetric quantitative analysis with review of Osmosis, mass action and reversible reaction.

Some time must be spent on Enzymes and Catalyzers in general. Must begin course with proper regard for exact technique with attention to detail. The Chemistry of Fats, Carbohydrates and Proteins must be presented in detail with sufficient reference to practical application of this knowledge to keep the students interested.

Thirty lectures are needed on Metabolism, Urine Analysis, Blood Analysis. Milk and Water Analysis must also be presented.

Four practical examinations are held in which the students must carry out accurate laboratory manipulation and a grade given commensurate with the accuracy of result reported. Five minute written quizzes are held at the beginning of each hour and students change papers and correct answers. This method insures full attendance and promptness as well as an accurate roll call.

Dr. Cope of Washington stated that normal Physical Diagnosis should be taught during first two years.

Dr. Billings said that the older physicians do not think in terms of Anatomy, Physiology and Chemistry but that the new generation of physicians should do this in order to get best results.

Wednesday morning a symposium was held on teaching of Public Health and Preventive Medicine, Pharmacology, Pathology and Bacteriology.

Dr. Vaughan stated that Public Health and Preventive Medicine is not taught in any definite way and marked improvement must be made. The lowest marks given at examinations of "The National Board" have been given in this subject. A separate course of two years was advocated for those who wish to specialize in Public Health. Medical degree not a pre-requisite for this course provided student has had proper training in Science.

Dr. Hale stated that the course in Public Health was optional in



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very frequent sequel of  
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salts required by the system  
together with the two potent dy-  
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SAMPLES AND LITERATURE UPON REQUEST

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Harvard for Senior Medical students and was intended as a basis for additional training.

Dr. Vincent, President of Rockefeller Institute, said that he could not add anything useful to the long discussion but if desired could demonstrate this by futile articulation.

Dr. Edmonds stated that courses in Pharmacology should first of all awaken interest of the student in this subject. He advised teaching well Pharmacology of only a few drugs which had been proven of merit. Informal conferences with students should be frequent and courses should follow directly the course in Physiology. Good note books and frequent quizzes should be insisted upon. Students do not know doses of drugs.

Dr. Ewing made a splendid report on the teaching of Pathology. A special library and museum should be a part of the Department. Pathology is a clinical subject and should be in intimate contact with hospital. Students learn much Anatomy at Post-Mortem examinations. Pathologists should be more appreciated and better paid. Pathology requires more special knowledge than any other subject and Pathologists deserve more appreciation.

The business meeting of The Association of American Medical Colleges was held Wednesday afternoon.

Of the fifty-four colleges belonging to the Association representatives of forty-five were present. Jefferson Medical College, Long Island Medical College and South Dakota University were elected as new members. Twenty-three of the schools have been re-inspected since 1918 and the remainder will be again inspected before next meeting.

The pre-medical requirement for Physics was changed to a minimum of 8 semester hours of College Physics and no allowance for high school Physics will be made in the future.

It was suggested that the pre-medical requirements for College Chemistry be increased to 14 semester hours because of the great need for more instruction in Organic Chemistry. This suggestion was not adopted although the opinion was prevalent that more preliminary instruction in Organic Chemistry was very advantageous.

Owing to the fact that colleges have so many different ways of reporting credentials the Committee on Pedagogics was instructed to make a report at the next meeting on the possibility of obtaining a uniform system.

Wake Forrest College and Medical Department of West Virginia were dropped from membership in The Association of American Medical Colleges as recent inspection showed that these schools were not living up to the requirements of the Association.

The Committee on degrees was instructed to confer with the Association of American Universities before making definite recommendations. About 20 copies of proceedings of the Association will be sent to each member so that a greater number of the Faculty of each Medical College will have an opportunity of reading in detail the many valuable suggestions made this year.

Dr. William Pepper of Philadelphia was elected President for next year and Dr. Fred Zapffe, Secretary.

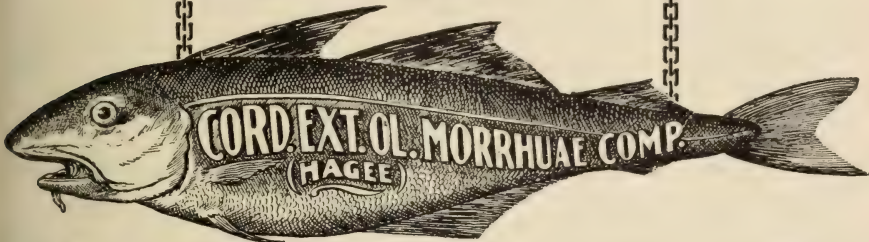
Hoping that this report will be of interest to you, I remain

Very sincerely yours,

Dr. William A. Pearson, Dean.

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(Late First Assistant Physician at the Middletown State Homoeopathic  
Hospital, New York.)



**Homœopathic Medical Society of the County of Kings, Brooklyn, N. Y.**—At the annual meeting in January the officers elected for 1919 were: President, Justus G. Wright, M.D.; Vice-president, Chester A. Peake, M.D.; Secretary, L. D. Broughton, M.D.; Treasurer, W. Fawcett Shaw, M.D.; Necrologist, J. Alex. Stewart, M.D.; Censors, Drs. W. H. Price, Orlando S. Ritch, Herbert Dana Schenck, Walter S. Rink and Stanley W. Pallister. The Legislative Committee are Drs. Schenck, Ritch, Reeve and Stewart. The secretary's report showed that fifteen new names were added to the roll in 1919, three deaths had occurred, Drs. Herman B. Street, Harriet Martineau and A. S. Brinkerhoff.

At the February meeting Dr. Fred D. Baker, 1144 Bergen St., Brooklyn, was elected to membership. A resolution presented by Dr. Ralph I. Lloyd designating the Hahnemanian Monthly as the official organ of the Society, was unanimously adopted.

Dr. William Frank Jacobs, superintendent of Cumberland Street Hospital, read a paper on "Present and Future Hospitals." Dr. Jacob's paper was a history of hospital work of the past, referring to the ancient attempts to treat the sick in groups, and discussing the changes in methods up to the present day institutions. Dr. James Taft Pilcher gave an interesting talk on his experiences in army hospital work and the results of his use of a preparation which he has named "Quino-Formal Solution," for the treatment of infected wounds. He stated that it was not to take the place of the Dakin-Carrel Solution, but where that was not acting well the substitution of the Quino-Formal Solution would give results. The solution is made as follows:

Quino-Formal Solution, (Pilcher):

R Quinine sulphate .....	1.00
Hydrochloric acid .....	0.50
Acetic Acid (Glacial 99%) .....	5.00
Sodium Chloride .....	17.50
Formal (40%) .....	1.00
Thymol .....	0.25
Alcohol (90%) .....	15.00
Water, q s ad .....	1000.00

1. Dissolve quinine in hydrochloric and acetic acids.
2. Dissolve sodium chloride in 500 cc. of water.
3. Dissolve thymol in alcohol.

Add No. 1 and No. 2, then the formal and finally add the thymol solution, No. 3, slowly, while constantly stirring the recipient solution. Add water to make one liter (1000 cc.).

Dr. James W. Fox gave a resume of his results in the treatment of influenza in children with homœopathic remedies; an excellent showing.

At the March meeting Dr. Stanley W. Pallister read an interesting paper on "Practical Points in the Surgical Treatment of Empyema," which was illustrated by a series of X-ray pictures shown by Dr. Charles Eastman, taken by Dr. Eastman in hospital service in France. The pictures represented the high class of work that was done for the soldiers in hospital treatment and the great care with which every case was studied in Dr. Eastman's service. One very interesting point brought out by the pictures was that it is not safe to enter an empyema for drainage at the low point shown in the picture as that had been demonstrated frequently as due to induration and thickening of the pleura, the pus being above that edge. Dr. James Neary of the Carson C. Peck

Low Alveolar  $\text{CO}_2$  Tension  
Low Alkali Reserve  
High Hydrogen-ion Acidity of Blood  
High Hydrogen-ion Acidity of Urine  
Acetone Bodies in the Urine  
Air Hunger

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Hospital read the notes of a case of gangrene of the lung which had come in his service at Flower Hospital, the patient being operated on by Dr. E. Welles Kellogg, and after a stormy convalescence the patient recovered. Dr. Kellogg discussed the paper.

L. D. Broughton, Secretary.

**Central Pennsylvania Homœopathic Medical Society.**—The annual Harrisburg meeting of the Central Pennsylvania Homœopathic Medical Society met in Harrisburg at the Hotel Bolton at 1 P. M., when 14 members responded to the roll-call.

Dr. Moyer, of Columbia made his inaugural address as President.

Two new members were proposed and duly and unanimously elected to membership in the Society: Dr. R. E. Pilgram, of Harrisburg, Dauphin County; Dr. J. S. Seitz, of Glen Rock, York County.

Under New Business Dr. Swartz of Harrisburg stated that the coming State Meeting was to be made a success. That Governor Sproul had been asked to come to the banquet and that the Governor was to speak. A general discussion of the State Society meeting in Harrisburg consumed the main part of the afternoon. Dr. C. M. Rhodes of Harrisburg is Chairman of the entertainment committee and Dr. Pilgram is chairman of the exhibiting committee.

Dr. Piper of Tyrone then entered the meeting-room and was accorded the floor. He made a plea to buck up with States dues, to get on the job for the coming State meeting and that the Blair County Society would do its share of the expense.

Dr. Hartman spoke on the preparation of papers for the State meeting.

Dr. Snyder of Lancaster then entered the room and was accorded the floor during a discussion on legislation in this State concerning the Osteopathic and Health Insurance Bills before the House, etc. Dr. Snyder stated that he was an invited guest at a meeting not long ago in Lancaster of the Lancaster Medical Club and there met and talked with Dr. Van Sickle when he was asked to speak before the local Central Homœopathic Society concerning the quick and active measures to be exercised in reference to Medical Legislation.

Dr. Hartman of Harrisburg then moved that the contribution to Medical Legislative conference be raised to \$5.00, seconded by Dr. C. M. Rhodes and unanimously carried by the Society.

Dr. Pilgram appointed Dr. Burnite and Dr. Mills with him on the exhibitors committee.

Dr. C. M. Rhodes appointed Drs. Perkins, Parker and Sayres on the entertainment with him.

Dr. C. M. Rhodes was ordered by general consent of the members present to obtain underwriters to foot the great majority of expense for the coming State meeting in Harrisburg. Six or seven members together pledged \$100.00 each to start the ball rolling.

Dr. Hartman was then appointed on the Publicity Committee to assist Dr. Bernstein.

The Committee on Constitution and By-Laws then reported and Dr. Hartman moved that the matter be held over until the next meeting.

The following essayists for the York meeting in June were appointed: Dr. P. Noll, York; Dr. Snyder, Lancaster; Dr. Hendrixson, New Holland; Dr. Williams, Philadelphia.

After an unusually lively and spirited and entertaining afternoon the meeting was adjourned at 4.30 P. M. to meet in York on June 10, 1920.



## Quotations from Doctors: No. 2

"The many cases of ovarian neuralgia that I have encountered in my practice during the past fifteen years, have been treated with hot applications of



I frequently use a weak solution of menthol over the part . . . then I dry the field and apply Antiphlogistine. The analgesic effect is instantaneous, and the general result is highly satisfactory to myself and my patients.

In dysmenorrhea I adopt the same procedure, making the application over the symphysis, etc. Antiphlogistine always serves me well."

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**Homœopathic Medical Society of the County of New York.**—The regular meeting of the Homœopathic Medical Society of the County of New York was held at the Academy of Medicine, 17 West 43rd St. Thursday, April 8th, 1920. In the temporary absence of the President and Vice-President the meeting was called to order by the Necrologist, Dr. P. C. Thomas at 8:24 o'clock. Attendance 32.

The minutes of the last meeting were read and approved.

Dr P. C. Thomas, Necrologist, presented a brief but comprehensive report of the life of the late Dr. E. G. Tuttle, and the "Memorial Committee," consisting of Drs. George W. McDowell and George A. Shepard contributed a choice and chaste set of resolutions and on motion the Secretary was requested to send a copy of the resolutions to Mrs. Tuttle.

The Bureau of Materia Medica and Therapeutics, J. P. Seward, M.D., Chairman, presented a paper entitled "The Role of Medicine in the Treatment of Gallstones and Urinary Calculi" by George F. Laidlaw, M.D.

The essayist spoke extemporaneously and among other things said: "This subject may be divided as follows, Influence of treatment during an attack and our ability to prevent recurrence of attack. In gallstone colic when pain is severe and agonizing hypodermic of morphia is absolutely necessary.

"Have also had prompt and satisfactory results from the use of Calc. Carb. 30, Calc. Carb. 200 and Berberis and Hydrastis. In cases of less severe type Phosphate of Sodium has done good work. Have had fifty cases all told, thirty of which under medical treatment have been cured, the other twenty cases have required and received surgical care."

Unless signs of septic infection, chills, fever and sweat are present advises leaving stone or stones in gall bladder.

If stones are not removed he fully appreciates the possibility of the danger of the development of cancer, or of perforation but considers the operation fully as dangerous as leaving them remain where they are.

By the use of carefully selected remedies we convert an active case into a latent one.

Have had gratifying results in the use of  $\frac{1}{2}$  Drachm of Turpentine  $\frac{1}{2}$  oz. of Ether and  $\frac{1}{2}$  oz. of alcohol, 30 drops every 2 or 3 hours.

Chelidonium Maj. 10 drops every 2 hours. Phosphate of Sodium 1 dr. three times a day.

In twenty of the fifty cases cited (all of which were eventually operated) some may have been neuralgia of the Gall Bladder, but all of them had been given turpentine and ether combination.

Surgical aspect.—Operation is called for in recurrent attacks, becoming more severe and failing to respond to medicine.

A cure might be effected if we knew the cause of the formation of Gall Stones, but I do not think we know the etiology of gall stones. Diet does not seem to affect recurrent attacks; some persons may have an attack following some indiscretion but most cases do not seem to be affected thereby.

In ten of the above operative cases, post-operative pain was present, which was readily controlled by the use of turpentine and ether, cinchona and chelidonium.

Have had twenty-five cases of Renal Calculi. If pain is excessive advises use of morphine during the attack. Calcarea Carb. has served me well in some of these cases. Would not leave calculi in the kidney; if left there they will destroy the kidney. Have these patients eat plenty of water cresses. Hydrangea and Berberis are very useful remedies.

# Hay Fever Time

1920 JUNE 1920						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
						6

1920 MAY 1920						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

1920 JULY 1920						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
4	5	6	7	8	9	10
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1920 AUGUST 1920						
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## For Spring Sufferers

Affected by the pollens of spring grasses, and subject to so-called "Rose Cold" or Spring Hay Fever, treatment is usually begun early—in April or May—at least four to six weeks before the expected attack.

Sheppegrell reports an analysis of 707 cases treated with pollen extract, of which 89% showed satisfactory results, 4% showed little or no improvement, and 7% discontinued treatment before the result could be noted. In no case was there an aggravation of symptoms. (Public Health Reports, Vol. 34, No. 31, 1919).

## Mulford Hay Fever Pollen Extract (Spring)

Contains proteins of the pollens of timothy, rye, orchard grass, sweet vernal grass and red top grass, accurately standardized in physiological salt solution.

It is furnished in convenient syringe and vial containers.

*Immunize Early Against Hay Fever*

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44244-m

# Mulford

THE PIONEER BIOLOGICAL LABORATORIES



Every case of suspected renal calculi demands an X-ray to determine its location and whether any damage has been done to the kidney tissues.

Lithia water, vichy, Carlsbad water but H<sub>2</sub>O is best of all used in abundance. Stone in the bladder is a surgical proposition, as it is so easy to operate. I do not know of any solution which will dissolve calculi in the bladder.

Discussion: Dr. R. F. Rabe: Homœopathy does not apply to pathological end products. Homœopathy has its limitations in these cases as in others. I have seen gall stones disappear under the administration of properly selected homœopathic remedies.

In many cases of calculi it is absolutely necessary and humane to make use of a hypodermic of morphine to relieve excruciating agony.

Dr. E. P. Swift: I agree with Dr. Laidlaw in the main. In some cases morphine must be used, but my experience has taught me that the carefully selected homœopathic remedy given between the attacks, even for months or years has given me very satisfactory results.

Dr. G. Stearns: Has had nineteen cases in which he has made use of twelve homœopathic remedies.

Dr. B. G. Clark: Has used with good results, China, Chelid, Calc, Carb. Lycop. and Sulph. For the severe pain he has found it necessary to use morphine.

Dr. E. D. Franklin: For the prevention of recurring urinary calculi he has found cutting off almost entirely of animal food and the drinking of plenty of water as most efficacious.

The Bureau of Pathology and Preventive Medicine, E. D. Klots, M.D., Chairman, presented a paper entitled "A Demonstration of Universal Pathological Specimens from the Metropolitan Hospital," by John G. Hiss, M.D.

Carcinoma with metastases to all of the organs of the body and two cases of aneurism (Syphilitic) illustrated by choice lantern slides and the pathological specimens of these cases were the subjects discussed by Dr. Hiss.

Prof. Larkin, Pathologist of Metropolitan Hospital, in a very comprehensive manner opened the discussion and explained the various microscopical sections made of these cases and thrown on the screen for our edification.

Dr. Geo. F. Laidlaw: I have been very much interested in the matter under discussion and can only voice the feelings of those present, that we have been very highly favored in having such a truly scientific paper presented to us.

On motion of Dr. Ver Nooy, seconded by Dr. House a very cordial vote of thanks was tendered Dr. Hiss and Prof. Larkin for the very highly instructive papers presented.

Meeting adjourned at 10:53 P. M.

Charles Ver Nooy, Secretary.

**Homœopathic Medical Society of the County of Philadelphia.**—The regular monthly meeting of the Homœopathic Medical Society of the County of Philadelphia was held at Hahnemann Medical College, Thursday evening, April 8, 1920.

There were 22 members present.

The meeting was called to order by the president Dr. G. W. MacKenzie at 9.10 o'clock.

Arsenic and Mercury are Indispensable in the Treatment of Syphilis. We recommend

## **SALVARSAN or NEOSALVARSAN**

(Arsphenamine-Metz)

(Neoarsphenamine-Metz)

powerful and easily administered spirocheticides, which are as efficacious as the imported products,

and

## **BICHLORIDOL or SALICIDOL**

(Mercury Bichloride)

(Mercury Salicylate)

put up in COLLAPSULES (compressible ampules), which insure accuracy of dosage with a minimum of pain after intramuscular injection.

This combination of anti-luetics has no superior in the therapeutic field. Literature upon application to

**H. A. METZ LABORATORIES, Inc.**

**122 Hudson Street**

**New York**

## **“After That Attack of Influenza”**

The constantly growing number of patients who have never completely recovered from an attack of influenza or pneumonia, emphasize the great importance of giving the utmost care and attention to the stage of convalescence. Every function needs to be supported and stimulated, and the nutrition of the whole body restored as near to the normal as possible. In

## **Gray's Glycerine Tonic Comp.**

a great many physicians have found so efficient and dependable a means of insuring complete and satisfactory recovery in the majority of cases of influenza, that they have come to employ it as a matter of routine.

Patients who are placed on “Gray's Glycerine Tonic Comp.” as soon as the temperature subsides, rapidly regain their strength and vitality. The influence of “Gray's Tonic” as a post-influenzal tonic and reconstructive is shown not only by the prompt and gratifying effect on the whole body that follows its use, but also by the notable freedom it assures from complications and sequelae

**The Purdue Frederick Company**

**135 Christopher Street**

**New York City**

The minutes of the previous meeting were read and approved.

There were no committee reports.

No report of censors.

There was no unfinished business.

No new business.

Dr. John A. Brooke presented a clinical case of spastic paralysis of the right leg, which has existed from birth. The patient was operated two and a half years ago; a double severance of the adductor muscles and stretching of the hamstrings was performed. The operation improved the patient considerably; however, during the past year the spasticity is returning again.

Another case presented by Dr. Brooke was a dislocation of the clavical from the sternum upward and forward on the right side. This was produced by being thrown from an automobile. The right arm was placed in a plaster cast for five weeks in a vertical position without improvement. The bones were then wired together and function returned.

The first essay was presented by Dr. Charles H. Seybert entitled Infantile Eclampsia. The paper was discussed by Dr. W. D. Bayley and Dr. C. S. Raue.

The second paper was presented by Dr. W. D. Bayley entitled Resorcin. The paper was a discourse on the use of Resorcin in the treatment of pneumonia.

The meeting adjourned at 10.45 P. M.

Theodore K. Gramm, M.D., Secretary.

**The Pennsylvania State Homœopathic Medical Society.**—President Piper announces the following appointments of Bureau Chairmen for the Harrisburg meeting in September next: Homœopathic Institute and Clinical Medicine, R. W. McClelland, Pittsburgh, Pa.; Ophthalmology, Otology and Laryngology, J. W. Stitzell, Hollidaysburg, Pa.; Paedology, E. C. Blackburn, Lock Haven, Pa.; Surgery, Gynecology and Obstetrics, G. W. Hartman, Harrisburg, Pa.; Pathology, Geo. A. Hopp, Philadelphia, Pa.; Sanitary Science, P. H. Gerhardt, Reading, Pa.

**Connecticut Homœopathic Medical Society.**—The seventeenth annual meeting will be held at Hartford, May 18, 1920. A very full and valuable programme has been provided. Save the day and be sure to attend.

H. A. Roberts, Secretary.

**For Sale.**—A Homœopathic practice well established in a flourishing city 13 miles from Philadelphia. Splendid opportunity for an up-to-date man in surgery, also nervous and chronic cases; contract work. Collections good. House and office centrally located. Reasons for selling, work too hard. Send replies to O. Q. Z., care of Hahnemannian Monthly, 1435 Spruce Street, Philadelphia, Pa.

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#### DEATHS.

Charles C. Curtis, graduate of Hahnemann Medical College, Chicago, 1874, died March 14, from nephritis at the age of 76, at his home in San Pedro, Calif.

Fred Carter Newcomb, graduate of Cleveland Homœopathic Medical College, 1898, died March 17 from uremia at the age of 52, at his home in Akron, Ohio.

Michael Vandervoort, graduate Hahnemann Medical College, 1868, died at the age of 77 on March 10, at his home in Guthrie, Okla.



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NOW KNOWN AS SUCH TO ALL DISPENSING  
PHARMACISTS

THESE designations may now be used interchangeably by the physician when prescribing the preparation originally known only as Glyco-Heroin (Smith).

As a safeguard against having worthless imitations of the preparation dispensed, it is suggested that the physician use the name

## GLYKERON

which is non-descriptive and more distinctive, when prescribing GLYCO-HEROIN (SMITH) for **Cough, Asthma, Phthisis, Pneumonia, Bronchitis, Laryngitis, Whooping-Cough and kindred affections of the respiratory system.**

DOSE—The adult dose is one teaspoonful every two hours, or at longer intervals as the individual case requires.

For children of ten years or more, the dose is from one-quarter to one-half teaspoonful; for children of three years or more, five to ten drops.

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The composition of GLYCO-HEROIN (SMITH) has not been modified in the slightest degree.

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MARTIN H. SMITH COMPANY

New York, U. S. A.

## HAHNEMANN COLLEGE NOTES.

Chas. R. Hutcheson, Editor-in-chief.

**Athletics:—Basket Ball.**—Our team experienced a most successful season in spite of the handicap of having neither a practice hall nor a coach at our disposal. The other teams were well coached, and indeed we sincerely hope and believe the time is not far distant when we shall have our own coach and our own hall. The teams comprising the City Intercollegiate Basket Ball League were: Hahnemann, Textile, Philadelphia College of Pharmacy, Temple Dental School, and The Philadelphia College of Osteopathy. The competition was very close during the entire season and it was by only a very narrow margin that we were unable to carry away the laurels, finishing, as we did in second place.

The following men represented Hahnemann and deserve much credit for making the success of the team what it was: Toomey (Captain), Brewer, Briggs, Haas, Guyler, Miller, Vischer and Richards.

**Senior Commencement:**—The commencement for the graduating class of 1920 will be held on June 3rd, in the Ball Room of The Bellevue-Stratford, Philadelphia, Pa. The musical program will be furnished by a Symphony orchestra from eleven until eleven-thirty in the morning. The main program for the occasion will begin promptly at eleven-thirty. The speaker will be Hon. Simeon D. Fess, Chairman of Educational Commission of the House of Representatives, Washington, D. C., previously President of Hiram College, prior to which time he was very closely affiliated with the History Department of the University of Chicago. Mr. Fess is a most accomplished orator with a most extensive knowledge of American History and will choose for his subject "Americanism."

There will be no reserved seats at the Commencement.

The Alumni Association will hold the annual meeting at the College during the afternoon of the same day at 3 P. M., following which a Banquet will be tendered to the graduating class in the evening, which no doubt will be held at the Adelphia Hotel as has formerly been the custom.

**Track:**—On March 16th, the first of the two track meets was held in the Central Branch of the Y. M. C. A. It was a triangular meet, teams representing Hahnemann, Philadelphia College of Pharmacy and Philadelphia College of Art and Textile. Hahnemann had a very capable team, winning all the field events, consisting of the Broad Jump, High Jump and Shot Put. We were handicapped, however, in the track events, owing to the scarcity of material. The second meet occurred on April 13th and again the other colleges were pushed to the limit. Textile captured first place in each meet, with Hahnemann taking second. This is indeed something of which we can all be proud and much is anticipated as the season progresses in the line of track events.

The different teams amassed the following number of points in each meet: Phila. Inter-Collegiate Track Meet, March 16th: Textile, 32 points; Hahnemann, 28 points; Phila. College of Pharmacy, 28 points. April 17th: Textile, 33 points; Hahnemann, 29 points; Phila. College of Pharmacy, 18 points.

Toomey (Captain), Golden and Dalton were the high scorers in the latter meet.

The Track Team is entered in the Penn Relays, West Chester Normal Meet—Glen Mills Meet, and in several other dual meets with other colleges of the city.

Keep a keen eye on our work, everybody and give us your support.

**Baseball:**—With the advent of the balmy air of spring, the old baseball bug has again entered our system and with the material as shown by the daily practice, the best season in the annals of Hahnemann is contemplated. While the financial question was one of importance, yet with the manner in which every man of the college came to the support of the team, and with the support of the college as a single unit for the success of the team, we indeed anticipate a most successful season.

The Schedule arranged is as follows: April 17th, West Chester Normal, away; April 24th, Bryn Mawr Main Line League, Away; May 1st, Philadelphia College Textile Arts, Home; May 15th, Penna. Military College, Away; May 22nd, Swarthmore College, Home.

**Juniors:**—It is probably safe to say that the mind of the average Junior at the present time is a jumble of keynotes mixed with presentations (or, more likely, presentiments) and furthermore, the leading keynote should be designated as hard work, while the chief presentiment, imminent in the minds of all, is the possibility of some hard-hearted prof. (mythical we hope) departing too far from the beaten track as to endanger our prospects for being Seniors next year.

The activities of the class, aside from the aforementioned examination fever are rather limited with the one exception of the Year Book which is steadily assuming more tangible form due to the efforts of the Editor Snader and his able assistants. A large part of the work will be done during the summer vacation when the entire class will be given definite assignments. The book will be published early next year, and will be full of pep and boost for Hahnemann and something catchy so that each one of you will want to purchase at least one.

**Sophomores:**—At last our ambitions have been realized—we are now obliged to carry stethoscopes. Seems as though we were real doctors, strutting around with such valuable instruments in view.

The course in Toxicology has proven a most valuable science. Determinations for the amounts of nicotine in all the popular brands of tobacco, both smoking and chewing, have been made and we are now prepared to submit most valuable information to all nicotine habitues. The class as a whole deserves much credit for their analyses along this line, working under most trying and adverse circumstances, in view of the prohibition of smoking either in the lecture rooms as well as orders from the Fire Marshal to the same effect in the corridors, which seems to make tobacco an article foreign to the students of Hahnemann.

**Second Year Science:**—We are informed that the new Physics Text for next year will contain what is technically known as Prof. Schmidt's Heat Theory. It is briefly stated as follows: "With temperature over 78 degrees F. and pressure constant, close proximity of students during examinations is likely to prove detrimental to all concerned."

Mr. McCollum of our class who tries to make us believe his name is La Rossa, is contemplating a special course to those students who find difficulty in learning organic chemistry from his text book.

**First Year Science:**—If anyone sees any stray cats prowling around loose—do your duty and remember what stray cats did for us.

Information wanted! What will remove the odors of cats from the hands. This is a necessary inquiry because some find it difficult to satisfy their hunger when dining, due to the presence of such foreign material.

Of course every man enjoyed his Easter vacation. What is home for,



but to enjoy one's self? Ask "Bob" Stroh and "Segs" Shurshon—they know.

Here's to the success of the class as philosophers—we'll be able to add more to this interesting study as we progress.

**Announcements:**—Final examinations for the Medical Students of the College will begin on May 24th, while those for the School of Science will begin one week later, May 31st. The later date is set for the School of Science in view that it is necessary to cover a period of 33 weeks that is the required time set by the Board.

Dr. Speakman will deliver several lectures on Medical Ethics to the Seniors prior to the end of the term.

The portrait of Dr. Clarence Bartlett, Professor and head of the Department of Medicine, was recently presented to the College by the Penna. State Homœopathic Medical Society and has been permanently placed upon the walls of Lecture room No. 1. The likeness of Prof. Bartlett is indeed a very good one and we hope as the years go by, that the portraits of many more of our distinguished and capable professors will adorn the walls of old Hahnemann.

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**Communication from the President of the American Institute.**—Program: The program this year has been worked out, with as great care as possible, to provide something in every Bureau, Section and Department which will be of professional interest to the Homœopathic profession generally.

Purpose of the A. I. H.: We believe that the A. I. H. is one of our greatest sources of Post Graduate training. With that interpretation of the matter there are to be presented at the meeting of the A. I. H. this year many important and interesting papers, demonstrations and addresses.

Publicity: The institute is a most prolific field for the promotion of publicity and this program in its various open meetings and public gatherings, has arranged well for that.

The A. I. H. This Year: The assembling of the A. I. H. this year means not only getting together papers and discussions of medical topics but it means also the congregating of all the Homœopathic forces for the general good of the Homœopathic cause.

Forces Present: Among these forces will be the Congress of States, our host, the Ohio State Society, the College Alliance, the Federation of State Boards, the Council on Medical Education, the American Pharmacal Association, the American Homœopathic Hospital Association, the National Homœopathic Women's League, the Institute Women's Fraternity, the various fraternities and Alumni Associations, etc, etc, all of which have special, well worked out programs to present.

Special Features: As special features I would call your attention to the Bureau of Physical Science, which is entirely new to the program of the A. I. H. The purpose of this is to bring to the law of similars scientific as well as clinical demonstration of its propriety and effectiveness. This whole Bureau will be replete with new and interesting things.

Mr. Kettering of Dayton, Ohio who is to address the Institute on the Electron Theory will bring to the A. I. H. the most interesting information regarding the efficiency of the Homœopathic remedy ever produced. This address alone will be well worth the entire time and expense of those in attendance.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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JUNE, 1920

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**A Text-Book of Physiology**, for Students and Practitioners of Medicine.  
By Russell Burton-Opitz, M.D., Ph.D., Associate Professor of Physiology, Columbia University, New York City. Octavo Volume of 1185 pages with 538 illustrations. Philadelphia and London: W. B. Saunders Company, 1920. Cloth, \$7.50 net.

Is there a physician of older vintage than 1910 who has not felt within him a desire to review the advances in physiological knowledge made since graduation more than a decade ago? Perhaps we have put the period back too long, because it is alleged that medical students forget their physiology between the termination of their second year and time of graduation. Really we are afraid that many of them do so.

In many respects physiology furnishes a very important part of the fundamental principles of diagnosis and treatment. Its study by physicians in active practice should be encouraged. It has always been a pleasure therefore to have the opportunity of welcoming a new textbook on the subject. The reader of such a work must not expect within its pages the presentation of anything more than absolutely established facts. For example, let us turn in this book to the pages devoted to the pituitary body. We find that the entire subject is presented in four octavo pages, furthermore, all data are stated with the clearness of diction that comes with clearness of thought on the part of the writer;

very different indeed from the rapid fire battery of words utilized by some authors and entirely destructive of the communication of ideas. One must not expect in dealing with such a subject to hear all the wildest theories and products of curiosity and imagination misdirected. The pineal gland is discussed in three-quarters of a page.

We can heartily recommend this text-book to our readers. Although there are nearly twelve hundred pages in the book, it is made easy to handle by reason of the use of a light weight paper of excellent quality.

**Arterio-Sclerosis and Hypertension** with Chapters on Blood Pressure.

By Louis M. Warfield, A.B., M.D., F.A.C.P. Formerly Professor of Clinical Medicine, Marquette University Medical School; Chief Physician to Milwaukee County Hospital, etc., etc. Third edition. St. Louis: C. V. Mosby Co., 1920. Price, \$4.00.

This work has been accorded sufficient medical approval to demand three editions. The author is a physician of extensive experience and therefore has had opportunities for practical knowledge of the subject matter. Arterio-sclerosis is not regarded as a disease with a definite etiologic factor, but rather as a degenerative process affecting the arteries following a variety of causes more or less ill defined. Syphilitic arteritis is, however, viewed as an entity as the cause is known, and the lesions are characteristic.

Much new material and many new figures have been added to this edition. The chapter on blood pressure has been much expanded, and some original observations have been recorded. The entire subject matter has been presented with the "personal touch" or "point of view" of the author, for which he should be accorded credit.

The chapters on blood pressure will be especially pleasing to the reader in that they present all that is positively known on the subject. Facts are clearly stated. Theories are avoided. A relatively short time is thus required on the part of the physician, who after all cares but little for extensive discussions concerning debatable theories.

The mechanical work on the book is of unusual excellence. The type is easy to the eye; illustrations are well executed; and the paper is of the best.

**Diseases of the Chest and the Principles of Physical Diagnosis.** By George

W. Norris, M.D., Assistant Professor of Medicine in the University of Pennsylvania, and Henry R. M. Landis, M.D., Assistant Professor of Medicine in the University of Pennsylvania, with a chapter on Electrocardiograph in Heart Disease, by Edward Krumbhaar, Ph.D., M.D., Assistant Professor of Research Medicine in the University of Pennsylvania. Second Edition, Thoroughly Revised. Octavo Volume of 844 pages with 433 illustrations. Philadelphia and London: W. B. Saunders Company, 1920. Cloth \$8.00 net.

The appearance of the first edition of this work was an event of more than usual importance in the literature of diseases of the chest. Immediately "Norris and Landis" became the leader and the authority. The admirable system with which subjects were presented, the clearness of statements, and the evident desire to present facts as they are and not according to tradition appealed to professional confidence. It is not surprising therefore that the first edition of the book was exhausted in





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Supplies the organism with those indispensable mineral elements:

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**Calcium            Iron**

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less than two years and that there remained a demand for a new edition. In one respect the new can be expected to improve on the old. About all that can be hoped for is that additional facts shall be presented. We find therefore a new section on Spirochetal Bronchitis, elaborations of the articles on Influenza, Streptococcus Empyema, Chronic Inflammatory Conditions of the Lungs of Uncertain Etiology, Calcification of the Lungs, Pneumopericardium, etc.; of which Influenza and Streptococcus Empyema are the most important.

**Surgical Shock and the Shockless Operation through Anoci-Association.**

By George W. Crile, M.D., Professor of Surgery, School of Medicine, Western Reserve University, Cleveland; and William E. Lower, M.D., Associate Professor of Genito-Urinary Surgery, School of Medicine, Western Reserve University, Cleveland. Second Edition of "Anoci-Association" Thoroughly Revised and Rewritten. Octavo of 272 pages with 75 illustrations. Philadelphia and London: W. B. Saunders Company, 1920. Cloth, \$5.00 net.

Accumulating experience in the civilian clinic and in field and base hospitals in France, has added much to the corroborative evidence of the soundness of the fundamental principles of anoci-association and of its practical application. Hence the necessity for the rewriting of the former edition.

The authors have presented as concisely as possible the principles upon which the doctrines of anoci-association have been founded and their practical application. No space has been wasted upon various theories, which after all if not backed by practical confirmation are worse than useless.

**Sexual Impotence.** By Victor G. Vecki, M.D., San Francisco, California.

Sixth Edition. 12mo. of 424 pages. Philadelphia and London: W. B. Saunders Company, 1920. Cloth, \$3.00 net.

This may be said to be strictly a medical book of use to the physician as to the surgeon. The subject is one old though it be, that has been grossly neglected by the profession, and exploited by the charlatan. This is all the more reason why legitimate medicine, and particularly the general practitioner who comes in close personal contact with his patients, should give it serious consideration. About one fourth of the text is devoted to prophylaxis and treatment, the technique of which is well within the scope of all.

**For Sale.**—A Homœopathic practice in the City of Pittsburgh. Centrally located to business section of city. This business has been established for thirty-five years and makes money. Only reason for selling, or quitting the business is because of sickness. Will sell or will rent to some good man. Address, Charles C. Williams, M.D., 624 Warrington Ave., Pittsburgh, Pa.

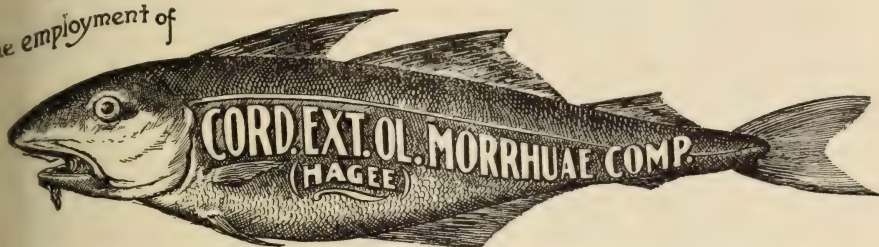
**To the Homœopathic Physicians of The United States of America.**—Again we have the pleasure to renew our Annual greeting, and to communicate at once an important advance in the cause of International Homœopathy.

The last Council Meeting was called for The Hague in August 1914. Many delegates were enroute from many countries when the tocsin of

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## THE EASTON SANITARIUM EASTON, PA.

PHYSICIANS and friends desiring to place any aged invalid or mild mental patient in a quiet, select, well-furnished home where they will receive the best of care, will do well to visit this place before deciding elsewhere.

Booklet sent on application.

C. SPENCER KINNEY, M.D.,

(Late First Assistant Physician at the Middletown State Homoeopathic Hospital, New York.)



war sounded, and postponed the assembly of Council indefinitely.

The Acting Committee has since been on the qui vive for the coming together of Council at the earliest possible date. The hour has arrived for the summoning of the best brains in Homœopathy the world over, to consider and give uplift to our Great Cause.

The Colleagues in Holland have unanimously decided to invite the International Homœopathic Council to meet at The Hague on August 26-27-28, in the present year. This is the first meeting of Council since the War, and it is earnestly hoped that every Society of Homœopathic physicians in every country will send a delegation to the Council Board. No more important meeting in the interests of Homœopathy has ever been held; and every Homœopathic Physician visiting The Hague at that time will be most cordially welcomed at the Council meeting.

Owing to the great access of travellers to Holland during the summer, it is most desirable to give notice as early as possible of an intention to visit The Hague in order that the necessary Hotel accommodations may be ensured. Pray communicate at once with the local Secretary:

Dr. E. C. Tuinzing, Haringvliet 26, Rotterdam, Holland,  
or to the Corresponding Secretary:

Dr. C. Granville Hey, London Homœopathic Hospital,  
Great Ormond St., London, England.

who will be happy to receive applications for the reservations of Hotel accommodation for delegates and visiting physicians.

The programme in general is the Reconstruction of the International Forces in Homœopathy; and a consideration of the aid that prosperous areas can bring to the help of those less happily circumstanced.

We are, yours fraternally

John Preston Sutherland,  
President of Council.  
George Burford,  
Secretary of the Acting Committee.  
C. Granville Hey,  
Corresponding Secretary.

**The Eightieth Annual Meeting of the Massachusetts Homœopathic Medical Society** was held at the Massachusetts Homœopathic Hospital, East Concord St., Boston, on Wednesday, April 14, 1920 at 10.00 A. M. From 10.00 to 12.30 A. M., special clinics were held in all the departments of the Out-Patient Department of the Hospital. Interesting cases were presented and methods of treatment demonstrated. Those who were interested in particular subjects had an opportunity to see the specialists at work with the patients. At the Robinson Memorial (Maternity Department) a special ante-natal clinic was held and methods for determining acidosis shown. Other demonstrations were made as clinical material permitted.

From 11 to 12 o'clock, in the amphitheatre of the Out-Patient Department, Dr. Watters had charge of a demonstration of the methods of taking blood for examination, mixing and administering arsphenamin, and spinal puncture.

At 12 o'clock, in the same room, methods of using radium, the ultra violet ray and the portable X-ray machine were shown. The usual surgical clinics at the hospital were held for those especially interested in surgery.

After a luncheon at 1.00 P. M., the Business Session was held at

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2.00 o'clock, which consisted of: Reading of Records of the last meeting; report of the Treasurer and Auditor; unfinished business; new business and the annual appointment to the Fund Committee by the President; the report of the Committees, Fund, Herbert C. Clapp, M.D., Legislative, Wesley T. Lee, M.D., Registration and Statistics, Harry J. Lee, M.D., Election, David L. Belding, M.D.; report of Necrologist, Frank A. Gardner, M.D., reception of Delegates from other societies; and the election to membership in the Society, William H. Clewley, M.D., Boston. The officers elected for the coming year were: President, Dr. George N. Lapham, Boston, Mass.; First Vice-President, Dr. Charles T. Howard, Boston, Mass.; Second Vice-President, Dr. Edgar A. Fisher, Worcester, Mass.; Recording Secretary, Dr. Nathan H. Garrick, Boston, Mass.; Corresponding Secretary, Dr. Benjamin T. Loring, Watertown, Mass.; Treasurer, Dr. Thomas M. Strong, Boston, Mass.; Chairman Board of Censors, Dr. Wesley T. Lee, Boston, Mass.

At 2.45 P. M. the following papers were presented in the Auditorium of the Evans Memorial Building: "The Relation of Certain Factors of Hospital Administration to the Professional Work" by H. M. Pollock, M.D., Superintendent of Mass. Homœopathic Hospital. "Gastric Ulcer," Presentation of cases, by Charles T. Howard, M.D., Surgeon Massachusetts Homœopathic Hospital; "Focal Infection; Some Complications and Sequelae," Clinical demonstration, by W. F. Phillips, M.D., Physician Massachusetts Homœopathic Hospital. After which there was a general discussion of the papers.

At 6.30 P. M. there was a dinner at Young's Hotel, at which Wesley T. Lee, M.D., made the presidential address on "The Democratization of Medical Practice" and Lt. Gov. Channing H. Cox also gave an address.

The Committee of Arrangements for the meeting consisted of: Wesley T. Lee, M.D.; Thomas M. Strong, M.D.; W. F. Phillips, M.D.; Plumb Brown, M.D.; Leslie P. Leland, M.D.

**Homœopathic Medical Society of the County of Kings, Brooklyn, N. Y.**—The 528th regular meeting was held April 27, 1920, at the Medical Library, Brooklyn. Dr. Walter R. Iszard read the notes of a case of adenofibroma operated upon by him recently which was in the perineum of a man. The growth was not connected with the prostate or bladder and the patient made a good recovery. Dr. W. H. Donnelly, a visitor, read an interesting paper on glandular enlargements in children, including tubercular conditions, syphilis, and secondary infections from localized diseased surfaces. This paper was discussed by Dr. Lloyd, who spoke of his studies in eye conditions in tuberculosis and the diagnostic value of the Von Pirquet test, which had been successful in his studies. Dr. Howard T. Blair gave a sketch of the remedies and medical treatment of adenoma including local remedies and the homœopathic similimum. Dr. Theodore L. Pulvermacher, who recently returned from army service read a paper on Caesarian section, giving the statistics of 62 % mortality of early operators in comparison with the successful operation of to-day.

Dr. H. D. Schenck spoke of the great influence that had been exerted on the State Legislature by the Professional Guild in opposition to the compulsory health insurance law, which had been defeated again this year. The Guild in New York State is made up of the medical profession of all schools, dentists and pharmacists, and now numbers many thousands of members, with a paid executive secretary who devotes his time to legislative work, and to whose efforts the present results were attributed in a large measure.

L. D. Broughton, Secretary.



## Quotations from Doctors: No. 3

"While on the subject of 'Depletion' perhaps a report of the following case may be of interest: Male, 66 years of age—diabetic—; retired at night in usual health—woke in morning with pain in region of elbow, arm enormously swollen, veins like whip-cords, edema—pitting on pressure. Diagnosis: probably thrombosis of basilic vein."

"I advised complete rest of arm and applied



liberally, covering with cotton as usual." "Patient reported next day that bandage and cotton, also bed clothing, were literally *soaked with fluid*, swelling greatly subsided. After five days of above treatment, swelling all gone, circulation normal—thrombus disintegrated."

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**The Clinico-Pathologic Society of Philadelphia.**—The regular monthly meeting of the Clinico-Pathologic Society was held in the Hahnemann Medical College. Doctors Duncan Campbell and Carroll Haines of Woodbury, were elected to membership.

Dr. C. A. Bigler reported a case of Carcinoma of the Rectum operated by a modified Kraske operation. Doctor Tindall presented a case of Vernal Catarrh which has been under Radium Treatment by Dr. Benson.

A very enlightening paper on the Interpretation of Dental X-ray was presented by Dr. John J. McKenna and discussed by Drs. Post and Barker. Dr. George Hopp of the Hahnemann Hospital Pathological Laboratory presented a paper on the Significance of Spinal Fluid Examinations.

Joseph V. F. Clay, Secretary.

**Philadelphia County Homœopathic Medical Society.**—The regular monthly meeting of the Homœopathic Medical Society of the County of Philadelphia was held at Hahnemann College, Thursday evening, May 13, 1920. There were 23 members present. The meeting was called to order by the President, Dr. G. W. Mackenzie at 9.15 o'clock. The minutes of the previous meeting were approved as read. The nominations of officers for the ensuing year were made as follows: President, Dr. G. W. Mackenzie; First Vice-President, Dr. E. M. Howard; Second Vice-President, Dr. Emma T. Schreiner; Secretary, Dr. Theodore K. Gramm; Treasurer, Dr. Donald MacFarlan.

The nominations of Trustees to serve for three years are as follows: Dr. W. F. Baker, Dr. T. J. Gramm, Dr. E. M. Howard, Dr. P. A. Tindall, Dr. G. H. Wells.

The nominations of Censors are: Dr. W. C. Barker, Dr. W. H. Shane, Dr. W. A. Weaver.

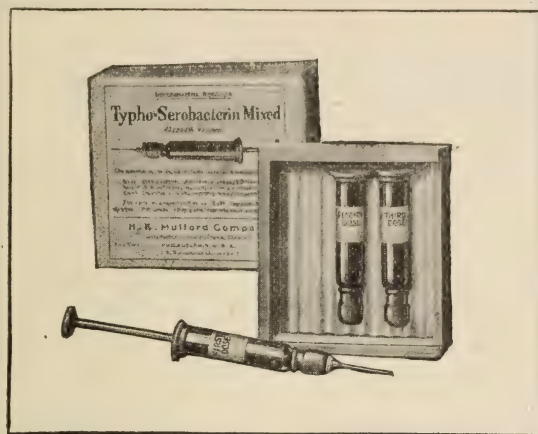
Dr. A. S. Ironsides read an interesting paper wherein he contrasted a cure effected by a Homœopathic remedy and a relief of symptoms produced by elimination. The paper was discussed by Dr. Donald MacFarlan.

Dr. W. F. Baker gave a demonstration of the effect produced upon a rabbit by feeding it antimonium tartaricum over a prolonged period of time. The effect upon the lungs appeared to be similar to a Pneumonia. The discussion was opened by Dr. G. A. Hopp.

The meeting adjourned at 11 o'clock.

Theodore K. Gramm, Secretary.

**Annual Dinner to Hahnemann's Graduating Class.** The graduating class of Hahnemann Medical College (Philadelphia) was entertained by the President of the Corporation, Mr. Chas. D. Barney, at the Huntingdon Valley Country Club on the evening of May 18, 1920. The entire class was present and associated with them as guests were Mr. Clarence Brown, Hon. E. L. Tustin, Mr. Walter E. Hering of the Board of Trustees, and Dean Pearson, Dr. D. Bushrod James, Dr. G. Harlan Wells, Dr. G. I. Palen, and Dr. Clarence Bartlett of the Faculty. Nine members of the College Orchestra were also present and furnished the music for the occasion. The latter added greatly to the pleasure of the occasion. They did marvellous work especially in view of the small opportunities medical students have for other than their strictly college duties. After the guests had done justice to the gastronomic features of the occasion, the speech making was opened by Mr. Barney, who introduced Senator



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Tustin as the first speaker. Mr. Barney's annual function has been distinguished by one characteristic feature. Each speaker when closing his remarks, nominated and introduced his successor. Each of the guests spoke his little piece, and the last orator was the president of the class, Mr. Guillian.

**Homœopathic Medical Society of the County of New York:** The regular meeting of the Homœopathic Medical Society of the County of New York was held at the Academy of Medicine, 17 West 43rd St. May 13th, 1920, the meeting being called to order at 8.18 P. M. by the President, Dr. J. H. Fobes. Attendance 39.

The minutes of the last meeting were read and approved.

On motion of Dr. P. C. Thomas seconded by Dr. Geo. F. Raynor, the following were nominated for Active Membership: Drs. Wm. A. Frascolla, 133rd St. and St. Nicholas Ave. and Richard R. Furlong, 297 Alexander Ave.

Dr. P. C. Thomas, Necrologist, presented a brief outline of the life of the late Dr. S. F. Wilcox.

The Memorial Committee through its Chairman, Dr. Wm. H. King, offered the following: The Committee appointed to report to this Society on the life work of our departed fellow member, Dr. Sidney Freeman Wilcox, feels that it can not do justice to a life so full and complete in his chosen field of activity. As a physician he represented the best and noblest of the traditions of that profession. This was alike recognized by his professional brethren and the laity to whom he administered. As a man his character was of the noblest. His humanity sprang from a kind sympathetic nature and was rooted in a deep brotherly love for mankind. His gentle, sweet nature endeared him to all with whom he came in contact, and his strong religious convictions gave him a sublime courage. With a knowledge of all these attributes, Be It Resolved, That in the loss of our brother and fellow member, Dr. Sidney Freeman Wilcox, we mourn one who has enriched the medical profession, who has left a most honored name, and whose taking off deprives us of a comrade who was always inspiring, a counselor on whose judgment we relied and whose friendship and loyalty we always appreciated.

Resolved—That these resolutions be spread upon the minutes of the Society and a copy be sent to his family.

Signed: William Harvey King, St. Clair Smith, William Tod Helmuth.

The Bureau of Clinical Medicine, Geo. F. Raynor, M.D., Chairman, presented a paper by Lieut.-Col. Frederick M. Dearborn, M.D., entitled "Parasitic Skin Diseases in the American Army in the Recent War."

This clean cut, able, scholarly and valuable paper was presented in the author's usually fascinating style, and held the close attention of those present.

The discussion was opened by Lieut.-Col. Wm. H. Bishop, M.D. and Lieut. W. A. Frascolla, M.D., who heartily agreed with all that Dr. Dearborn had said. Dr. Furlong discussed this paper briefly in the general discussion which followed.

Dr. Dearborn closed the discussion with a few brief practical remarks.

The Bureau of Eye, Ear, Nose and Throat, Harold A. Foster, M.D., Chairman, presented a paper by Captain L. E. Hetwick, M.D., entitled "Suggestions to General Practitioners in Regard to Ear Diseases."

This practical, thoughtful, carefully prepared and well delivered paper was very cordially received.

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The discussion was opened by Dr. Eckhardt who spoke in terms of appreciation of the paper as rendered.

In the general discussion which followed, Drs. B. G. Clark, H. A. Foster and H. W. Paige participated.

Dr. Hetrick spoke at some length in closing the discussion, referring to some points brought out by the discussors.

Meeting adjourned at 10.27 P. M.

Charles Ver Nooy, M.D., Secretary.

### PERSONALS.

Walter J. Snyder, M.D., announces the removal of his offices, from 5300 Spruce Street to 418 South Forty-seventh Street, with entrance on Osage Avenue, May first, 1920.

Dr. R. A. Walther, announces the opening of his offices at 1825 Chestnut Street, Philadelphia. Genito-Urinary Diseases. Cystoscopic Examinations. Hours: 9 to 12, and by appointment.

Dr. William H. Dieffenbach has removed to 50 Central Park West, New York City. Office hours: 9 to 12.

Dr. John Edward Loftus, 2nd, announces that he has been honorably discharged from the service of the United States Navy, and has resumed practice, 605 and 606 Medical Arts Building, Sixteenth and Walnut Sts., Philadelphia. Hours: 9.00 A. M. until 1.00 P. M., other hours by appointment.

Dr. Plumb Brown, announces that after April 28, 1920, his office will be located in Room 304, Markarian Building, 175 State St., Boston. Telephone, River 46-W. Office Hours: 2:00 to 4:00 and 7:00 to 8:00 P. M. Sundays 12:00 to 1.00 P. M. only.

Dr. Samuel Hamilton of Pittsburgh has been ill with pneumonia, his fourth attack, but is completely recovered now.

Dr. Joel S. Kelsey has removed from Pittsburgh to accept a staff position at the Lee Memorial Homœopathic Hospital at Johnstown, Pa.

Dr. C. E. Sawyer, president of the A. I. H. was the guest at a banquet of the Allegheny County Homœopathic Medical Society on April 21st.

Drs. Pearson and Bernstein were the guests of the Western Alumni of the Hahnemann Medical College, at their meeting in March.

Dr. Frank B. Edmundson has given up the general practice of medicine to do X-ray work exclusively.

Dr. C. Harold Kistler of Ardmore, Pa. was married to Miss Ruth Helene Smith of Williamsport, Pa., April 10th, 1920. He has removed from 7 W. Lancaster Ave., to 22 Cricket Ave., Ardmore.

The Abington Memorial Hospital held its graduating exercises for the class of 1920 on Wednesday evening, May the twelfth at half past eight at the Nurses House, Abington, Pa.

### DEATHS.

Sidney Freeman Wilcox, graduate of New York Homœopathic Medical College, 1880, died at the age of 64 on April 20, while operating in Thrall Hospital, Middletown, N. Y., from cerebral hemorrhage.

Ernest Edgar Becket, graduate of Hering Medical College, Chicago, 1895, died on April 9th, at the age of 47, from cerebral hemorrhage.

Osmund Eells Goodrich, graduate of Hahnemannian Medical College,



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Chicago, 1866, died at his home in St. Joseph, Mich., at the age of 75, on Feb. 27, from senile debility.

James Edward Harper, graduate of Chicago Homœopathic Medical College, 1899, died on February 21, at his home in Assumption, Ill., at the age of 50, from sarcoma.

Russel Hathaway, graduate of Homœopathic Hospital College, Cleveland, 1876, died on February 27, at his home at Wellington, Ohio, at the age of 72 from neuritis.

John Abram Hunt, graduate of Boston University, 1893, died on February 13, at Taunton, Mass., at the age of 65, from carcinoma.

Mary Parker, M.D., a graduate of the Hahnemann Medical College of Chicago, 1910, died at her home in Waltham, Massachusetts on April 8th from carcinoma.

Valcollon Warsaw Mather, of Kansas City, Mo., a graduate of the Pulte Medical College of 1883, died in the Robinson Sanitarium, Kansas City, April 18th, from cerebral haemorrhage.

Peleg Francis Walker, graduate of the Boston University, 1881, died in Providence, R. I., on February 27th, at the age of 60 from heart disease.

Mary Johnson Cochran, graduate of Homœopathic Hospital College, Cleveland, 1895, died at Chester, Pa., February 12th from pneumonia.

Jennie Holman Griffin, graduate of Cleveland Medical College, 1895, died February 23, from pneumonia.

Belle Ogden Constant, graduate Hahnemann Medical College, Chicago, 1917, died February 19th, at Chicago, aged 49, from osteosarcoma.

Charles H. Wagner, graduate of Homœopathic Hospital College, Cleveland, 1873, died at his home in Minneapolis on March 1; aged 67.

Helene Siverine Lassen, graduate of New York Medical College and Hospital for Women, 1871, died at her home in Brooklyn, on March 25.

Brooks DeForest Norwood, graduate New York Homœopathic Medical College and Flower Hospital, died at his home at Westport, Conn., on March 20; aged 42.

John H. Young, graduate of Homœopathic Hospital College, Cleveland, 1874, died at New Cumberland, Pa., on March 23, at the age of 83.

William Vernon Van Norman, graduate of Cleveland Homœopathic Medical College, 1898, died at Los Angeles, on March 23, aged 44.

Dr. W. A. Barnes who graduated at Hahnemann College, Philadelphia, Pa., with the class of 1895, died at his home, Martinsburg, W. Va., on Thursday, May 6, 1920. Dr. Barnes practiced six years at Kittanning, Pa., after his graduation, but moved to Martinsburg, W. Va., in 1901, where he built a lucrative practice. He was a man of sterling worth and a successful physician.

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#### HAHNEMANN COLLEGE NOTES.

**Hahnemann-Lafayette Concert:** On May 13th, Lafayette Musical Clubs journeyed to Philadelphia to join with the Hahnemann clubs to present the first and finest combined musical concert ever produced by these organizations.

The men from Lafayette, numbering 40 in all, arrived in the city quite early in the day, assembled at the college, where the entire Hahnemann student body and many of the Faculty were in readiness to greet

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these men. Much enthusiasm for the event was created by the hearty cheers of both Hahnemann and Lafayette. At every angle, a feeling of absolute unity was apparent with the two colleges, a factor which could offer nothing but marked "Success."

Indeed, Hahnemann and Lafayette colleges have always been quite friendly in their relationship and quite recently, through the efforts of our late beloved Dr. Wm. B. Van Lennep, before the installation of a pre-medical course at Hahnemann, instituted a plan whereby the men would take a pre-medical course at Lafayette, further completing the course of medicine at Hahnemann. However, the plan did not entirely materialize, yet with such mutual feeling existing between the two colleges, has been a means of Hahnemann receiving a number of students from Lafayette, and at the present time, several of the men in attendance at Lafayette contemplate taking the medical course at Hahnemann.

Following several interesting tours through the college buildings the men from Lafayette were entertained individually by representatives from Hahnemann.

Promptly at 8.15 P. M. the walls of the Grand Ball Room of the Bellevue-Stratford echoed to the strains of Hahnemann and Lafayette. The Ball Room was most beautifully adorned with flowers and emblems of the two colleges and the contrast was so striking as to present a most attractive appearance.

A very large delegation from Lafayette accompanied the clubs, and with the excellent support given the Hahnemann clubs, both by the



Faculty, Doctors, Students and friends, made possible the most successful presentation ever produced by these clubs.

The program presented the following features:

Part I.

Lafayette Songs, (a) Way down in Easton; (b) Lafayette Fellowship Song; (c) Like a Queen Enthroned—Lafayette Glee Club.

Excerpts from Royal Vagabond, Cohen and Goetgel—Hahnemann Orchestra.

Baritone Solo, On the Road to Mandalay—James M. Herring (Lafayette).

The Charge of Prince Rupert's Men—Hahnemann Glee Club.

Harmony Rag, H. G. Nichols—Lafayette Mandolin Club.

Piano Solo, Polka De La Rein—James M. Fithian (Lafayette).

Rolling Down to Rio, German—Lafayette Glee Club.

Part II.

Overture Maritana, Wallace—Hahnemann Orchestra.

Baritone Solo, The Longshoreman—W. J. Walker, Jr., Assisted by Hahnemann Glee Club.

(a) Tri-State March; (b) Kissamee—Indian Novelty—Lafayette Mandolin Club.

Harmony Quartet, Selected—D. F. Mac Namee, H. F. Fell, H. R. Burgess, I. G. Acott, (Lafayette).

Beauties of Vienna, De Harpport—Lafayette Mandolin Club.

But They Didn't, Rogers—Lafayette Glee Club.

Hahnemann Song—Combined Clubs.

The program for the evening was concluded by dancing, during which event many new acquaintances became manifest between the friends of Hahnemann and Lafayette.

Indeed, much praise and congratulation for the success of the occasion is due Mr. Wm. J. Walker, '20 of Hahnemann, formerly a student of Lafayette. Mr. Walker worked untiringly, always with the interest of Hahnemann at heart and with the fervent desire to have Hahnemann attain that high degree in its social functions which it has attained in the science of medicine—second to none.

Further, much credit is due the Leader of the Hahnemann Orchestra, Mr. Robert Lehman and Mr. Harry Mark, leader of the Glee Club, for their untiring efforts and their manner of conduction and marked success of the clubs.

Lafayette leaders and clubs are also to be congratulated in their various productions, assuring them that at no time have the Hahnemann clubs united with another who have worked with such unison of purpose and realized such marked success.

While the receipts have not as yet been complete, yet the management have ventured to express the opinion that quite a substantial sum would be available to be turned over to the Bradford Memorial Fund.

Due to the marked success of the occasion, Lafayette is considering entering into a contract during the season of 1921, for a similar production, it being as yet undecided as to whether it will be staged in Easton or Philadelphia.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

JULY, 1920

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**Principles of Physiology.** By Ernest H. Starling, C.M.G., F.R.S., M.D., Hon.Sc.D. (Cambridge and Dublin), F.R.C.P., Jodrell Professor of Physiology in University College, London. The chapter on the sense organs revised and largely rewritten by H. Hartridge, M.A., M.B. Cantab. Third edition with 579 illustrations, 10 in color. Philadelphia: Lea & Febiger, 1920. Price \$7.50. pp. 1315.

Even during the five years of war which have elapsed since the appearance of the last edition, physiology has continued to advance, and the author has been obliged in revising the work to introduce a number of alterations, especially in the latter half, in order to make the presentation of the material more in accord with our actual knowledge. The chief changes affect the section on Sense Organs, which has been revised and largely rewritten by Dr. H. Hartridge. The fifty page increase in the size of the book is due entirely to the more adequate treatment of this subject.

To one conversant with medical literature, Starling has been recognized as an authority since the publication of the first edition of this work in 1912.

**Symptoms in the Diagnosis of Disease.** By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics and Diagnosis in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one time Clinical Professor of Diseases of Children

in the University of Pennsylvania; Commander U. S. N. R. F., etc., etc. 8th edition, thoroughly revised. Illustrated with 195 engravings and 9 plates. Lea & Febiger: Philadelphia and New York. 1920.

This work is one of the first published presenting the study of clinical medicine from the analytic as opposed to the synthetic standpoint. Like all books of its class it attained a high degree of popularity from the start. It presents, however, one important distinction from its competitors, in that it recognizes the immense field of laboratory diagnosis and the helplessness of the general medical man in his endeavors to avail himself of it by personal work. The author therefore has thrown the entire strength of his teaching upon the purely clinical or bedside phase of medical practice, and confines his remarks to the study and interpretation of symptoms and physical signs. He does this not because he denies the importance of the laboratory and other aids to diagnosis, but because the material he feels should be that in which the general medical man should be the most proficient, and of which he can best avail himself in practice, should be the subject matter of the work.

Although not a large book (535 pp.) the author's concise diction makes it encyclopedic as to quality of information. Its value is greatly enhanced by the most complete diagnostic index conceivable.

**A Diabetic Manual** for the use of Doctor and Patient. By Elliott P. Joslin, M.D. Assistant Professor of Medicine, Harvard Medical School; Consulting Physician Boston City Hospital, etc., etc. Illustrated. Second edition thoroughly revised. Lea & Febiger, Philadelphia and New York. 1919. Price, \$1.75.

There is a wrong way to treat a diabetic, and there is a right way. The latter demands that the patient be educated. We are fully aware that there are many if indeed not the majority, who feel that in accordance with the old adage "a little knowledge is a dangerous thing" the less the patient knows about his disease and the more he depends upon his physician, the better will be his progress. An extended experience has taught us that diabetics must be educated. They cannot and will not keep themselves under the care of a physician with the degree of attention to details that the occasion warrants. At one time, we believed the less the diabetic knew the better, but we feel that we have gained wisdom.

Joslin's manual gives the patient just the information he should have, but he cannot assimilate it without the assistance of his physician. Diabetes of all diseases is the one which should not be a lazy man's work to treat. Even with Joslin's Manual, the management of a case is not child's play.

We heartily believe that all diabetics should possess this book, and study it in conjunction with their attending physicians.

**Regional Anesthesia.**—(Victor Pauchet's Technique). By B. Sherwood Dunn, M.D., Officier D'Academie; Surgeon (Colonel) Service de Sante Militaire de Paris; Physician to the Cochin Hospital. 294 pages with 224 illustrations in the text. Philadelphia, F. A. Davis Company: London, Stanley Phillips, 1920. Cloth \$3.50 net.

During the last few years anesthesia by injection of such drugs as cocaine and novocaine has made many advances. To-day such injections are not confined to the nerve terminals of the operative field, but the principal nerve trunks to such an area are anesthetized along their course.





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To be successful under these circumstances requires considerable practice and anatomical knowledge, and the best methods in the various regions of the entire body are carefully mapped out in this volume. In addition the indications, contra-indications and necessary armamentarium are considered in detail.

The French, beginning with Professor Reclus, have always been great adherents of local anesthesia and Professor Victor Pauchet is to-day recognized as the leading exponent of regional anesthesia in France. It is upon a resume of his writings, together with those of Sourdat and Labaure, that this book is founded.

**Laboratory Manual of Pharmacology**, including *Materia Medica*, Pharmacopaedics and Pharmacodynamics, Price \$3.50 net. By A. D. Bush, C.Sc., M.D. Professor of Pharmacology, University of North Dakota. Illustrated with full-page plates many in colors. Published in Philadelphia, by F. A. Davis Company, English Depot, Stanley Phillips, London, 1919.

This is a college text-book that has been prepared with the fact in mind that the majority of medical students do not expect to become specialists in pharmacology but practitioners in general medicine. Therefore the knowledge gained by study derives its chief value in relation to practice. The interests of the student are considered as paramount to the interests of the specialist. The manner of presentation of the various subjects is well calculated to infuse enthusiasm among students in the pharmacologic laboratory. Of course it must be understood that time does not permit the students to investigate many drugs experimentally, but let him be the investigator and sponsor for one or two for which he will take an active interest through his student life and thereafter, and unquestionably the medical science will be greatly benefited thereby.

The work is well illustrated, especially in the matter of diagrams, half-tones, colored plates and schematic tables.

**A Laboratory Manual of Physiological Chemistry**. By Elbert W. Rockwood, M.C., Ph.D., Professor of Chemistry and Toxicology and Head of the Department of Chemistry in the University of Iowa; Author of an introduction to Chemical Analysis for Students of Medicine, Pharmacy and Dentistry. Fourth Edition, Revised and Enlarged. Illustrated with one colored plate, three plates of microscopic Preparations and Seventeen Engravings. Price \$2.00. Published in Philadelphia by F. A. Davis Co., English Depot, Stanley Phillips, London, 1919.

Physiological Chemistry is rapidly coming to the front as an important adjuvant of clinical study, and especially so in relation to the investigation of endocrine disorders. It is not by any means a new subject. The first edition of the present volume was issued twenty-one years ago. It is only, however, within recent years that physicians have come to realize the clinical importance of the subject. Rockwood's book is a small one, having been prepared on the principle that too complete a guide is an embarrassment to the student, therefore he has not attempted to make his work too conclusive or encyclopedic. Most of the procedures of modern clinical chemistry are presented, those employed in research work alone are omitted.

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C. SPENCER KINNEY, M.D.,

(Late First Assistant Physician at the Middletown State Homoeopathic Hospital, New York.)



**Principles and Practice of Infant Feeding.**—By Julius Hess, M.D., Professor and head of the Department of Pediatrics, University of Illinois College of Medicine; Chief of Pediatric Staff, Cook County Hospital, Consulting Pediatrician, Municipal Contagious Hospital, Chicago. Second revised edition. F. A. Davis Co., Publishers, Philadelphia, Penna. Price, \$2.50 net.

The name of Dr. Hess is sufficient recommendation for the excellence and practical value of this work. The fact that a second edition has so promptly followed upon the first appearance of this work proves that the book has met with a friendly reception by the profession and that it has become a popular treatise on infant feeding.

In writing this book Prof. Hess acted on the principle that the best results in teaching pediatrics are obtained when the theory of feeding is combined with a study of actual cases. In this method of teaching he has succeeded admirably and he presents the difficult and rather complicated subject of infant feeding in a practical and lucid manner.

The author does not limit himself to any one particular "school" of infant feeding but gives a fair discussion of all of the theories and methods of feeding which merit serious consideration. He also enters fully into a discussion of the anatomy and physiology of the digestive tract of the infant; metabolism in infancy; the bacteriology of the intestinal tract in health and in disease; the effect of malnutrition upon the susceptibility to infection; nutritional disturbances in breast-fed infants and in artificially fed infants. There is also a valuable appendix dealing with proprietary foods and such general subjects as nursing, care of food during travelling, case taking, general development and measurement at different ages. The feeding of older children is also thoroughly discussed in a special chapter upon this subject. To the general practitioner who is looking for a concise, practical presentation of the subject of infant feeding and at the same time for a book which is not too technical and presumably only addressed to the specialist in this field we can heartily recommend Prof. Hess' able work.

**Bureau Appointments of the Homœopathic Medical Society of Pennsylvania.**—Bureau of Materia Medica and Therapeutics.—Samuel Friedmann, of Scranton, Chairman; Drs. O. S. Haines, R. L. Piper, Daniel Bohn, L. A. Wesner, W. B. Bogges, W. S. Piper, Anna C. Clarke and D. S. Kistler.

Bureau of Pathology: Dr. Geo. A. Hopp, chairman; Drs. O. F. Barthmaier, L. Pierce, H. M. Read, S. W. Sappington, and Jno. G. Wurtz.

Bureau of Surgery: Dr. W. G. Hartmann, of Harrisburg, Chairman; Drs. D. Roman, L. T. Ashcraft, J. D. Elliott, H. L. Northrop, R. C. Casselberry, D. B. James, C. A. Bigler, J. E. James, W. C. Mercer, H. P. Leopold, Jno. L. Peck, Fred. E. Howell.

Bureau of Clinical Medicine: Dr. R. W. McClelland, Chairman; Drs. W. F. Edmunson, H. S. Nicholson, R. S. Marshall, Clarence Bartlett, E. L. Nesbitt, W. R. Williams, G. Harlan Wells, G. Morris Golden, Ralph Bernstein, O. H. Paxson.

Bureau of Ophthalmology, Otology and Laryngology: Dr. J. W. Stitzell, of Hollidaysburg, Chairman; Drs. H. W. Champlin, Henry Biermann, Geo. W. Mackenzie, Frank O. Nagle, Gilbert J. Palen, J. V. F. Clay, Geo. J. Alexander.

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Hepatic  
Torpor  
Biliousness  
Indigestion  
Cholangitis

*DOSE: One to two tea-  
spoonfuls three times a day*

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**Connecticut Homœopathic Medical Society.**—The annual meeting of the Connecticut Homœopathic Medical Society was held in Hartford, Conn., on May 18, 1920, the President, Dr. Westervelt, in the Chair. The papers were presented as per programme, and were well discussed.

President's Address, M. Z. Westervelt, M.D., New Haven; Radium Therapy, Major C. L. Graham, M.D., Lee Hospital, Rochester, N. Y.; Homœopathic Materia Medica in Pediatrics, Geo. W. Palmer, M.D., Rockville, Conn.; Abdominal Adhesions, Alonzo J. Shadman, M.D., Forest Hills Hospital, Forest Hills, Massachusetts; Touch Tenderness in Abdominal Conditions, Joseph H. Fobes, M.D., New York City; Foot Conditions and Their Treatment, Gilbert Mason, M.D., Boston, Mass.; The Relation of Some Dermatoses to the Recent War, Frederick M. Dearborn, M.D., New York City.

The following officers were elected for the ensuing year: President, Dr. W. S. Putney, of Milford; Dr. G. W. Palmer, of Rockville, Vice-president; Dr. Henry P. Sage, of New Haven, Treasurer; Dr. Herbert A. Roberts, of Derby, Secretary; Dr. Carl J. Hart, of New Britain, Censor for 5 years; Drs. Royal E. S. Hayes of Waterbury and H. A. Roberts of Derby were elected to represent the society in the Congress of States and Drs. Westervelt and Hooker were appointed alternates.

**Central Pennsylvania Homœopathic Medical Society.**—The regular meeting of the Central Pennsylvania Homœopathic Medical Society was held June 10, 1920, in York at the York Country Club. Twenty-five members responded to the roll-call after which the minutes of the previous meeting were read and corrections made. There was no deferred or old business, no new members proposed nor a report of censors.

Under new business Dr. Hartman of Harrisburg, speaking in behalf of Dr. C. M. Rhodes, absent, stated that concerning the entertainment of the visitors at the State meeting in Harrisburg in September that the Mayor of Harrisburg will make an address, that other good men shall speak and that things are shaping up for a banner meeting.

Dr. Pilgram, chairman of the exhibitors' committee, stated that there had been 13 spaces out of a total of 36 sold at the Penn-Harris Hotel in Harrisburg. That the floor space was a great expense and that something must be done further to obtain the principal Homœopathic Drug-gists to take an exhibit at the spaces there.

President Moyer then introduced Dr. W. R. Williams of Philadelphia and there followed a talk of forty minutes of most interesting and masterful understanding of "The Clinical Aspects of the Rheumatic Heart." Due to the lateness of the dinner there was no time for discussion.

The President then called for the next speaker and Dr. N. R. Perkins, of Dorchester, Mass., gave an interesting and well selected paper on "What Electricity May Do for the Hypertrophied Prostate." Dr. Perkins showed the instruments of his own invention as he has used them in many successful diseases of the prostate gland.

Dr. E. S. Snyder was then accorded the floor and there followed a very lively and well prepared paper on "Health Insurance."

It was moved that Dr. Snyder's paper be published in the "Hahnemanian Monthly."

Considerable discussion on Dr. Snyder's paper took place.

After motion was made and seconded for adjournment the meeting was adjourned to meet in Columbia in August.

H. M. Read, Secretary-Treasurer.



## Quotations from Doctors: No. 4

"In cervicitis and its allied conditions, the best remedial agent, in my opinion, is



"It can be applied warm, on a wool tampon and packed in the vagina against the cervix, and supported lightly with a gauze dressing, held in place with a T-bandage. Care must be taken not to pack so tightly as to prevent drainage.

"Pruritus, from vaginal irritation, is alleviated within twenty-four hours by the application of Antiphlogistine. The osmotic and hygroscopic properties of this preparation, make it one of the best means of treating pelvic congestion."

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**Hahnemann Medical College; Meeting of the Alumni Association.—**

The Annual Meeting of the Alumni Association of Hahnemann Medical Hospital and College of Philadelphia was held June 3rd, in the College at 3 o'clock in the afternoon. The President, Dr. Ernest L. Clarke, of Media, Pa., presiding. Dean Pearson presented the report from the Faculty showing a very successful college year and told of the bright prospects for Hahnemann's future. His report will be printed in full in the Hahnemannian.

The Necrologist reported the death of seventeen members during the year.

The entire graduating class consisting of thirty-seven members was elected to membership.

Dr. John W. Shower of York, Pa., was elected an Associate Member.

It was announced that as soon as an accurate list of the members of the Alumni Association who served in the World War was completed, a tablet containing all their names and commemorating their service would be placed on the college wall.

The officers elected for the new year follow: President, Dr. E. T. Prizer, '96, Lancaster, Pa.; 1st Vice-President, Dr. A. W. Westney, '97, Atlantic City, N. J.; 2nd Vice-President, Dr. W. F. Beggs, '93, Newark, N. J.; 3rd Vice-President, Dr. N. F. Lane, '91, Philadelphia, Pa.; Permanent Secretary, Dr. B. K. Fletcher, '95, Philadelphia, Pa.; Provisional Secretary, Dr. W. C. Hunsicker, '95, Philadelphia, Pa.; Treasurer, Dr. R. W. Larer, '98, Philadelphia, Pa.; Executive Committee (3 years), Dr. H. P. Leopold, '96, Philadelphia, Pa.; Dr. J. G. Wurtz, '07, Pittsburgh, Pa.; Dr. F. W. Smith, '03, Philadelphia, Pa.

B. K. Fletcher, Secretary.

**Dean's Report for the College Year of 1919-1920.**—Gentlemen of the Alumni: The College year just ending has in some respects been even more difficult than the college year of 1918-1919.

The general spirit of unrest was apparent. Transformation from the tension of war to the tranquility of peace requires considerable time and the period of adjustment is as definite in medical education as in civil life.

The Hahnemann Medical College of Philadelphia has been very fortunate indeed during this critical period. Our Trustees have taken unusual interest in college affairs, the Faculty has been exceptionally faithful and conscientious in performing arduous duties, the students have shown a splendid attitude and spirit.

It is doubtful if any medical college has so well adapted itself to the many exceptional conditions.

We are indeed thankful for the return of many members of our Faculty who were in the military service. Not only did these men carry with great credit the Hahnemann banner into all parts of the military service but they have come back to us with enthusiasm, with energy and with loving loyalty and have literally made the college hum.

Drs. Hartley and Sylvis deserve special mention, for these two men accomplished with great credit the very difficult task of lecturing on Anatomy after Dr. Northrop.

The cost of maintaining the college has been much greater this year yet it is expected that no actual deficit will result. The college has been maintained on the usual high educational plane and no expense has been eliminated which would interfere with the students' best interests.

# Hay Fever Time

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1920 SEPTEMBER 1920						
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26	27	28	29	30		



## For Fall Patients

affected by the pollens of ragweed, golden rod, corn, etc., and subject to Fall Hay Fever, treatment is usually begun early—in July or August—at least four to six weeks before the expected attack.

Dr. W. Scheppegrell, Chief of the Hay Fever Clinic of the Charity Hospital, New Orleans, reports an analysis of 707 cases treated with pollen extract and vaccines, of which 89% showed satisfactory results, 4% showed little or no improvement, and 7% discontinued treatment before the result could be noted. In no case was there an aggravation of symptoms. (Public Health Reports, Vol. 34, No. 31, 1919.)

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It is with regret that we must announce an increase in tuition and laboratory fees for next year but it is hoped that the Alumni will all realize that this is absolutely necessary in order to properly provide for the Hahnemann standard of instruction.

Loan funds have greatly helped many students this year. In fact had it not been for these funds a number of our deserving students would have been compelled to leave college.

The largest loan fund comes from "The Hering Loan Fund" which was announced last year. The interest on \$40,000 is loaned to deserving students and the students' notes are taken with the distinct understanding that the money is to be returned at a later date to assist another student. This fund is administered by three Trustees who are at present, Mr. Gribbel, Mr. Tustin and Dr. Eberhard.

The Woman's Homœopathic League have loaned \$200.00 this year to students. The class of 1896—\$150.00 and I might add that this class has done this each year since its 20th Anniversary and I have now another check from the class of 1896 for \$150.00 for next year. The class of 1888—\$150.00. The Pittsburgh Alumni \$150.00 and I might add that the Pittsburgh Alumni have been helping students for several years and I have now another check from the Pittsburgh Alumni for \$150.00. The Northeastern Pennsylvania Alumni Association helped a student this year and will again next year and the Homœopathic Physicians from Trenton will help a student next year.

It is not my desire to make this report simply a recital of the loan funds supplied by friends of The Hahnemann Medical College but I do want you to realize that it takes a large amount of fortitude for a promising young man to begin the study of medicine when jobs are plentiful, wages high and the cost of living higher. Several excellent men have already been enabled to graduate from "Hahnemann, the best medical college in the world," solely because of our loan funds and this number will be larger as the years go on.

Endowments: The magnificent endowment of \$500,000 from Mr. George Elkins makes the total endowment of the corporation considerably over one million dollars.

Mrs. Irma Hering Evans, grand-daughter of Constantine Hering, has by her own personal effort raised an endowment of nearly four thousand dollars for the Thomas Lindsley Bradford Library Memorial Fund. The interest on this amount of money will largely pay for subscriptions to our medical magazines.

A patient of Dr. Golden has given the money to buy an electrocardiograph and other endowments are in sight. The college needs several substantial endowments to provide suitable funds for the departments teaching the fundamental medical branches. Perhaps one of your wealthy patients would like to have a laboratory named for him.

Recently Sir Humphrey Rolleston of The Royal College of Physicians, Colonel H. J. Waring of the Royal College of Surgeons and Dr. Norman Walker of the University of Edinburgh inspected the Hahnemann Medical College of Philadelphia. These three famous British physicians were well pleased with the advantages we give our students and informed Dr. Berring that our clinical facilities for teaching are

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(Neoarsphenamine-Metz)

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This combination of anti-luetics has no superior in the therapeutic field. Literature upon application to

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The constantly growing number of patients who have never completely recovered from an attack of influenza or pneumonia, emphasize the great importance of giving the utmost care and attention to the stage of convalescence. Every function needs to be supported and stimulated, and the nutrition of the whole body restored as near to the normal as possible. In

## **Gray's Glycerine Tonic Comp.**

a great many physicians have found so efficient and dependable a means of insuring complete and satisfactory recovery in the majority of cases of influenza, that they have come to employ it as a matter of routine.

Patients who are placed on "Gray's Glycerine Tonic Comp." as soon as the temperature subsides, rapidly regain their strength and vitality. The influence of "Gray's Tonic" as a post-influenzal tonic and reconstructive is shown not only by the prompt and gratifying effect on the whole body that follows its use, but also by the notable freedom it assures from complications and sequelae.

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second to none. Such a compliment coming from these men means much to the prestige of our college.

On May 13th, The Hahnemann Musical Clubs gave a joint-concert with the Lafayette Musical Clubs at the Bellevue-Stratford Ball-Room. This was a success in every particular and besides being a brilliant social affair which brought Hahnemann and Lafayette Colleges closer together, about three hundred dollars were turned over to the Thomas Lindsley Bradford Memorial Fund.

Our collection of military photographs is slowly increasing and we hope to have the military photograph of every graduate of Hahnemann who was in the service.

This collection of photographs will be taken to the meetings of The American Institute of Homœopathy at Cleveland where it will be on exhibition in the Hahnemann Headquarters, Room 228.

Gifts: The Alumni of The Hahnemann Medical College have presented to The Hahnemann Medical College a splendid oil painting of Dr. Clarence Bartlett. The class of 1920 has presented their Alma Mater with their composite photograph.

Dr. Joseph C. Guernsey has given the college a picture of Dr. Constantine Hering and other historic treasures.

Through the kindness of Dr. Bartlett the college library has received several medical publications and over one hundred and fifty dollars worth of new medical books.

Future: It is always dangerous to talk of the future for our chief concern should always be our work to-day. Perhaps it would not be out of place to say that the future looks bright and on the sunset of to-day a distinct vision is seen showing a larger college and a more modern hospital.

W. A. Pearson, Dean.

**Homœopathic Medical Society of the County of Kings, Brooklyn, N. Y.** The 529th regular meeting of this Society was held May 25, 1920, at the Medical Library, 1313 Bedford Avenue, Brooklyn, the president, Dr. Justus G. Wright, in the chair. Two names were added to the membership, Dr. F. T. Shatara, graduate of the P. & S., N. Y., '16, and Dr. Toyohiko Campbell Takami, graduate of Cornell, '06.

Dr. August Korndoerfer, of Philadelphia read a paper entitled: Hahnemann; Chemist, Physician, Philosopher. Dr. Korndoerfer's paper gave a sketch of Hahnemann's life in the period when he was translating books and when he was studying chemistry, describing the work then done as of itself sufficient to have placed Hahnemann's name high in science had he done nothing more. He believed that Hahnemann's early experience was a development to the greater discoveries of his later years.

Dr. Korndoerfer endeavored to show that what Hahnemann described as psora in its many phases was an early understanding of the symptoms now known to be due to the effect of the endocrine glandular secretions, and he described in detail the thyroid, pituitary, and suprarenal secretions and their effects upon the body both in health and when in excess or deficient, and the symptoms described by Hahnemann in his chronic diseases and other books.

The attendance was very large and the paper created a strong impression by its detail and logic. Dr. Korndoerfer received a rising vote of thanks at the close of the evening.

Dr. Orlando S. Ritch in response to Dr. Korndoerfer's paper spoke



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of the work of followers of Hahnemann in Brooklyn and gave an interesting history of the development of the school from 1840, the date of the first coming of a homœopathic physician to Brooklyn, to this time, 1920 and mentioning the men who had become prominent as homœopathic physicians.

During their visit Dr. and Mrs. Korndoerfer were the guests of Dr. and Mrs. W. W. Blackman.

L. D. Broughton, M.D., Secretary.

**The Pennsylvania State Homœopathic Medical Society.**—Fellow members of the Homœopathic Medical Profession: The next annual meeting of the Pennsylvania State Homœopathic Medical Society will be held at the Penn-Harris Hotel, Harrisburg, Pa., September 21st, 22nd, and 23rd. The splendid record established by homœopathic physicians during the recent epidemics which have devastated our country, demands that you show sufficient pride in your profession to join our State Society if you are not a member, to pay your dues if you are in arrears, and to consider it your absolute duty to come to Harrisburg on the dates mentioned ready and willing to assist us in every way possible to make this meeting of our State Society the best we have ever held. Splendid scientific papers will be read and discussed, matters of vital importance to every physician in the State will be considered, and your presence and opinion are needed.

The majority of the physicians throughout the State are active and alert and I have been accorded the most cordial hospitality everywhere. May I count on YOU? Fraternally,

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**National Homœopathic Clinical Day, October 19, 1920.**—Every homœopathic institution in the country is invited to have a day of clinics, both surgical and medical, on October 19, 1920.

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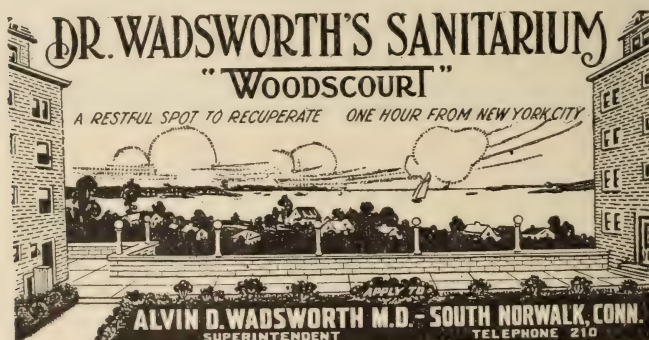


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**Maryland Homœopathic Medical Society.**—The Homœopathic Medical Society of Maryland held its 46th annual session at the Hotel Emerson, Baltimore, on Wednesday and Thursday, May 19 and 20, 1920; First Vice-President, Dr. W. T. Morrison of Elkton, in the chair. Papers presented included the report of surgical cases by Dr. M. Bowman Hood, the Homœopathic Therapeutics of Amenorrhœa, Menorrhagia and Dysmenorrhœa, by Dr. Robert W. Mifflin, a discussion of the most useful remedies in influenza opened by Dr. Eldredge C. Price, and continued by Drs. Russell, Wisner, Johnson, Thomas, Stauffer, and Mifflin. Dr. N. V. Wright read a paper which contended that the dangers of kissing as a cause of disease were grossly exaggerated, and which of course excited the attention of the ubiquitous newspaper man. On Thursday the papers included Genetic Psychology, a learned and well presented paper by Dr. F. E. Hesser; Modern Methods of Diagnosis of Diseases of the Stomach, by Dr. Wilbur F. Skillman, and a speech by Dr. Chas. E. Sawyer, President of the American Institute of Homœopathy. Dr. Clarence Bartlett, of Philadelphia, made some remarks concerning our duty to the organization of the homœopathic school and its institutions.

In the evening the annual dinner took place at the Hotel Emerson, 35 members being present. The post-prandial performance took the shape of an open discussion concerning the advisability of opening a Homœopathic hospital in Baltimore. Those present were practical in their remarks. The enterprise had advanced so far as the selection of a site, and the pledge of sufficient funds to make up for a deficit in running expenses, which of course means that the hospital will be opened before many months.

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THE HAHNEMANNIAN MONTHLY  
NEWS AND ADVERTISER

A Medical Newspaper

AUGUST, 1920

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**Pathogenic Microorganisms.**—A Practical Manual for Students, Physicians, and Health Officers. By Wm. Hallock Park, M.D., Professor of Bacteriology and Hygiene, University and Bellevue Hospital Medical College and Director of the Bureau of Laboratories of the Department of Health, New York City; and Anna Wessels Williams, M.D., Assistant Director of the Bureau of Laboratories of the Department of Health; Consulting Pathologist to the New York Infirmary for Women and Children; Assisted by Charles Krumwiede, Jr., M.D., Assistant Director of the Bureau of Laboratories; Assistant Professor of Bacteriology and Hygiene in the University and Bellevue Hospital Medical College, New York City. Seventh Edition, enlarged and 9 full page plates. Lee & Febiger: Philadelphia and New York. 1920. Price, \$6.00.

The first edition of this work was one of the pioneers in the field of bacteriological literature, and established a reputation for itself at once. It then bore the title "Bacteriology in Medicine and Surgery." Later the title was changed to that which it now bears, by reason of the increased knowledge of the protozoa and their cultivation and characteristics.

The present volume embraces much new material, and has been largely rewritten. Especial note should be taken of the chapters on Immunity. A chapter on "Media" prepared by Dr. Anthony is of special value, and utilized recent work on hydrogenation concentration. The sections on streptococci, on yeasts and on influenza bacilli have been extensively rewritten. The information gained during the influenza epidemic upon bacteria pathogenic to the respiratory tract and during the last part of the war with preventive measures against typhoid fever, paratyphoid fevers and wound infections, due to anaerobes, has been added. The chapter on Complement Fixation was revised by M. A. Wilson and W. C. Noble.

The volume is largely based upon the vast experience afforded by

the Laboratories of the New York City Department of Health and represents a large amount of individual work and investigation on the part of the authors.

The Trustees of Hahnemann Medical College and Hospital have made ample provision for a department devoted entirely to radium therapy. It has been placed under the supervision of Dr. Frank C. Benson, who will be at the Hospital daily and will have his regular office hours in connection with the service. Private patients may be referred to Dr. Benson at the Hospital.

Dr. Joel Melick has finished his term of service as interne at the Massachusetts Homœopathic Hospital, and has associated himself with Dr. Allen Corson, of Ocean City, N. J.

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**Concerning Arsphenamin Preparations.**—The Treasury Department has sent medical journals a warning concerning the use of untried preparations of arsphenamin, requesting that due publicity be given this fact and requesting that their use be discouraged. Thus far but five concerns have been licensed, and therefore have received governmental endorsement. One concern has been given a license for arsphenamin; the remaining four for both arsphenamin and neo-arsphenamin. Physicians who use these drugs should see to it that they use none but those accorded the Federal approval. It is easy to see that disregard of this warning may do harm to patients on whom they are tried. We believe that this warning is both timely and necessary. The physicians' motto should be "Not how cheap, but how good."

**Philadelphia County Homœopathic Medical Society.**—The regular monthly meeting of The Homœopathic Medical Society of the County of Philadelphia was held at Hahnemann College Thursday evening June 10th, 1920, at 9 o'clock.

The special order of business at this meeting was the election of officers at 10 P. M. for the ensuing year. Those elected are: President, Dr. G. W. MacKenzie; 1st Vice-President, Dr. E. M. Howard; 2nd Vice-President, Dr. Emma T. Schreiner; Secretary, Dr. T. K. Gramm; Treasurer, Dr. Donald MacFarlan. The Trustees elected to serve three years are: Dr. W. F. Baker, Dr. T. J. Gramm, Dr. E. M. Howard, Dr. P. A. Tindall, and Dr. G. H. Wells. The Censors are: Dr. W. C. Barker, Dr. W. H. Shane, and Dr. W. A. Weaver.

The scientific program consisted of a Symposium on Diseases of the Nose and Throat. Three very interesting and scholarly papers were presented. The first by Dr. Wm. G. Shemeley, Jr., "Atypical Temperatures Following Operations Upon the Nose and Throat." The second essay by Dr. G. J. Alexander, "Papilloma of the Nasal Septum." The third paper by Dr. H. S. Weaver, "Indications for Homœopathic Remedies in Nose and Throat Diseases." The discussion was opened by Dr. Theodore J. Gramm, who complimented the authors very highly upon their excellent essays. The other members who discussed these papers were Dr. H. S. Weaver, Dr. W. A. Weaver, and Dr. Donald MacFarlan.

The meeting adjourned at 10:45 P. M.

Theodore K. Gramm, M.D., Secretary.





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**Hahnemann Hospital Training School for Nurses.**—The graduating exercises of the Hahnemann Hospital Training School for Nurses were held in the Y. M. C. A. Auditorium on the evening of June 17th. The exercises included the opening prayer, and later an address by the Rev. Philip J. Steinmetz, music by Mrs. A. M. Adams, Mrs. Geo. W. Stewart, Dr. G. Morris Golden, Mrs. Paul Roberts. Announcement of Graduates by Mrs. J. M. Steele; awarding of Diplomas by President Chas. D. Barney, Presentation of class pins by the Directress of Nurses and Chief of the Training School, Miss Eva J. Hood; and presentation of prizes by Mrs. Jos. M. Steele.

The graduating class was as follows: Bertha Ashworth, Danville, Va.; Naomi G. Brown, Orwigsburg, Pa.; Cora Bone, Ocean Grove, N. J.; Ruth Batten, Lansdowne, Pa.; Elizabeth R. Clemens, Philadelphia, Pa.; Lulu M. Flory, Bangor, Pa.; Florence Foulke, Quakertown, Pa.; May Anna Gottschall, Pine Grove, Pa.; Elizabeth M. Jones, Minersville, Pa.; Emily J. Jennings, Camden, N. J.; Elva Pipgress, Philadelphia, Pa.; Alice Stout, Trenton, N. J.; Rose M. Schwan, Philadelphia, Pa.; Ruth H. Temple, Philadelphia, Pa., Sarah B. Weeks, Pleasantville, N. J.

**Homœopathic Medical Society of the County of New York.**—The regular meeting of the Homœopathic Medical Society of the County of New York, was held at the Academy of Medicine, 17 W. 43rd St., June 10, 1920; the meeting being called to order at 8:30 o'clock by the President, Dr. J. H. Fobes. Attendance 24.

The minutes of the last meeting were read and approved.

On motion of Dr. Rabe, seconded by Dr. Rankin, it was unanimously voted that the Secretary cast the ballot for the election to Active Membership of Drs. W. A. Frascolla, 133rd St. and St. Nicholas Ave., and Richard R. Furlong, 297 Alexander Ave. The Secretary announced their election.

Dr. Fobes read a clipping from one of the newspapers, written by Dr. J. P. Davin, of the New York County Medical Society, with reference to the appreciation of that Society of the action of Governor Smith in vetoing the "Chiropractor Bill," and on motion of Dr. Rabe, seconded by Dr. Grace M. Kahrs, it was unanimously voted that the Secretary of this Society send a letter to Governor Smith, voicing our sense of gratitude for his attitude in the matter.

The Bureau of Drug Proving and Clinical Research, Spencer Carleton, M.D., chairman, presented a paper entitled "A Partial Proving of Benzol," Preliminary Report by R. F. Rabe, M.D. He also spoke of provings of Iodine and Kali bich.

The paper was of a high order and contained many valuable points, somewhat along the line of paper read before this Society Jan. 8, 1920, by Prof. Hinsdale of Ohio State University.

This paper was ably discussed by Drs. Spencer Carleton and W. G. Crump.

Dr. P. C. Thomas spoke extemporaneously for about twenty minutes on the subject, "The Clinical Aspects of Pituitrin." The discussion was opened by Dr. G. F. Raynor. Drs. R. F. Rabe and E. G. Rankin participated in the general discussion which followed.

The Bureau of Pediatrics, Grace M. Kahrs, M.D., Chairman, were particularly fortunate in securing J. Ivemy Dowling, M.D., of Albany,

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N. Y., who presented a very scholarly and original paper entitled, "The Accessory Nasal Sinuses in Children," illustrated by lantern slides. The discussion was opened by Dr. R. A. Benson, who spoke in terms of deepest appreciation of the many valuable hints suggested in the paper, and in the general discussion which followed Drs. Eckhard and Young joined.

Dr. Dowling spoke very briefly in closing the discussion.

On motion of Dr. Rabe, seconded by Dr. Raynor, a very cordial vote of thanks was tendered Dr. Dowling for his able, practical, interesting and convincing paper.

Meeting adjourned at 11.10 P. M.

Charles Ver Nooy, M.D., Secretary.

**Annual Banquet of Hahnemann Medical College of Philadelphia.**—The annual Banquet of the Alumni Association of Hahnemann Medical College, of Philadelphia, was held at the Adelphi Hotel, Philadelphia, on the evening of June 3, 1920, the President, Dr. E. L. Clark, of Media, acting as toastmaster. Not quite 300 members were in attendance. Dr. Clark delivered the president's address, the main text of his remarks related to the importance of modifying the State regulations concerning the status or definition of a teaching hospital. Other speakers were Mr. Nathan M. Griffith, Rev. Floyd Tomkins, and Dr. Chas. R. Hutcheson.

**The Lehigh Valley Homœopathic Medical Society.**—The regular meeting of the Society was held at Seip's Cafe, Easton, Pa., on Thursday, June 10, 1920. After luncheon, the following papers were read: "Bureau of Hygiene and Sanitation" by Walter W. Seibert, M.D., Chairman; "Mental Hygiene" by Harry F. Hoffman, M.D., Asst. Supt. State Homœopathic Hospital, Allentown, Pa.; "Adaptation of Military Sanitary Measures to Civil Practice" by Harry L. Baker, M.D., Catasauqua, Pa.; "Retiring President's Address," Walter W. Seibert, M.D., Easton, Pa. The following officers were elected for the ensuing year: S. Clarence Swartz, M.D., President; H. F. Hoffman, M.D., Vice-President; H. L. Baker, M.D., Secretary; E. C. Statler, M.D., Treasurer; W. W. Seibert, H. I. Klopp, F. P. Lefferts, Censors.

**The Seventy-Second Annual Commencement of the Hahnemann Medical College of Philadelphia,** was held on Thursday morning, June 3, 1920 at 11.30 o'clock. In the absence of the President of the Corporation, Hon. Ernest L. Tustin presided. The invocation was by the Rev. Floyd Tomkins, S.T.D. The annual address to the graduating class was delivered by Hon. Simeon D. Fess, Chairman of the Committee on Education, House of Representatives, Washington, D. C.

The degrees of the college were then conferred upon the following: Wendell Jones Burkett, Audubon, N. J.; Charles Chellis Chesebro, Utica, N. Y.; Victor Manuel Cintra, Merida, Yucatan, Mexico; Charles Peter DeFeo, New Haven, Conn.; John Aloysius Doyle, Tremont, Pa.; Edwin Sartain Gault, Philadelphia, Pa.; John William Gebhardt, Pittsburg, Pa.; Giles Osborn Gardner, Utica, N. Y.; Harry Snyder Gingrich, Lickdale, Pa.; Raymond F. Goeringer, Wilkes-Barre, Pa.; William Helweg Guilium, Philadelphia, Pa.; Cecil William Hancox, Youngstown, Ohio.; Chester Ellsworth Hawn, Huntingdon, Pa.; Charles R. Hutcheson, Camden, N. J.; Stephen Emmanuel Hutnick, Wilkes-Barre, Pa.; Edward

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The Dean, Dr. Wm. A. Pearson then announced the hospital appointments as follows:

*Hahnemann Hospital, Philadelphia, Pa.*—John Aloysius Doyle, Tremont, Pa.; Edwin Sartain Gault, Philadelphia, Pa.; William Helweg Guiliam, Philadelphia, Pa.; Edward Clarence Kern, Montclair, N. J.; Robert Benjamin Kistler, Minersville, Pa.; Harry Berst Mark, Harrisburg, Pa.; Fred Hartzell Martz, Hollidaysburg, Pa.; Albert Mutch, Philadelphia, Pa.; Edward Smithers Ross, Philadelphia, Pa.; John Barratt Townsend, Frederica, Del.

*Women's Homœopathic Hospital, Philadelphia, Pa.*—Harry Snyder Gingrich, Lickdale, Pa.; Stephen Emmanuel Hutnick, Wilkes-Barre, Pa.; Joseph J. Scholtes, Minersville, Pa. and E. Pratt Woolard, Philadelphia, Pa.

*J. Lewis Crozer Hospital, Chester, Pa.*—Carlton Alfred Michael, Roanoke, Va.

*Pittsburgh Homœopathic Hospital, Pittsburgh, Pa.*—John William Gebhardt, Pittsburgh, Pa., Cecil William Hancox, Youngstown, Ohio, William Kirk Mathewson, Coatesville, Pa., Henry J. Reuter, Jeannette, Pa.; Raymond Linville Sheets, Beaver Falls, Pa. and Edmund Frederick Truter, Pittsburg, Pa.

*Hahnemann Hospital, Scranton, Pa.*—Raymond F. Goeringer, Wilkes-Barre, Pa.; Hugh Creston Stevenson, 3rd.; Pottsville, Pa. and Raymond Arthur Werts, Renovo, Pa.

*West Jersey Homœopathic Hospital, Camden, N. J.*—Charles Ruderow Hutcheson, Camden, N. J. and Myron Griffin Tull, Baltimore, Md.

*Wilmington Homœopathic Hospital, Wilmington, Del.*—Wendell Jones Burkett, Audubon, N. J.

*Utica Homœopathic Hospital, Utica, N. Y.*—Giles Osborn Gardner, Chesebro, Utica, N. Y.; Charles Peter DeFeo, New Haven, Conn.; Chester Ellsworth Hawn, Huntingdon, Pa., Raymond Scruggs, Danville, Va. and Ralph Somers Walter, Harrisburg, Pa.

*Utica Homœopathic Hospital, Utica, N. Y.*—Giles Osborn Gardner, Utica, N. Y.

*Flower Hospital, New York City, N. Y.*—Victor Manuel Cintra, A., Merida, Yucatan, Mexico.

*Rochester Homœopathic Hospital, Rochester, N. Y.*—James Norman Stevenson, Pottsville, Pa.

*Massachusetts General Homœopathic Hospital, Boston, Mass.*—J. Braden Thompson, Huntingdon, Pa.; William James Walker, Jr., Philadelphia, Pa.



## Quotations from Doctors: No. 5

"My patient, a dentist, scalded from the bursting of a vulcanizing flask, was in great agony. I hastily applied



the only thing convenient at the moment. Intended it for a temporary dressing until the ordinary substances used in such cases could be obtained. The relief was so great and instantaneous that the dressing was allowed to remain until a later visit, when upon its removal twelve hours after, the skin was found to be white and free from inflammation. Another application was allowed to remain for twenty-four hours. When discontinued there were no blisters, no redness, nor any evidence of the burn, excepting the eyelids and around the eyes where the Antiphlogistine had not been applied. Have used this preparation again and again in burns of the first degree with invariably good results."

F. E. C., M. D.,  
BROOKLYN, N. Y.

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**Drive for Nurses.**—The dearth of nurses is becoming so great that active measures are necessary to recruit pupils for the various training schools. Practically every hospital is running on less than 75 per cent. of its full quota; many on still less; some few have not felt the situation quite so acutely; but all are suffering.

Hahnemann Hospital Training School has started a drive. This consists in issuing some small stickers on which is printed: "All the Hospitals need nurses; make it your duty to secure one or more." The idea is that these stickers shall be affixed to all communications sent out from physicians' offices, thus interesting the laity, and making them alive to the situation. Those interested can obtain a small supply of these stickers from Miss Eva J. Hood, Directress of Nurses, Hahnemann Hospital, Philadelphia. Nothing more is required than the promise to use them.

**Pennsylvania State Society; Program Bureau of Sanitary Science.**—Dr. Paul H. Gerhardt, Chairman. 1. "The Venereal Problem," Dr. Edward K. Golding, Reading, Pa. 2. "Insidious Causes of Disease," Dr. Paul H. Gerhardt, Reading, Pa. 3. "Hygiene for School Children," Dr. Wm. M. Hillegas, Phila., Pa. 4. "The Program of Child Health in the State of Penna.," Dr. Ellen C. Potter, Chief, Division of Child Health, Harrisburg, Pa. 5. "Present Day Needs of Child Hygiene," Dr. Taliaferro Clark, Assistant Surgeon General, U.S.P.H.S., Medical Officer in charge of Field Investigations in Child Hygiene. 6. "The Physician's Part in the Public Health Program," Dr. Edward Martin, Commissioner of Health of the State of Penna., Harrisburg, Pa.

**Annual Meeting of Alumni Association, Boston University School of Medicine.**—The annual meeting of the Boston University School of Medicine Alumni Association was held on June 15, 1920, at Young's Hotel, Boston, Mass. Following the business meeting the Association adjourned to the banquet hall for one of the most delightful evenings ever experienced in the life of the Association.

The post prandials were presided over by the President of the Association, Dr. Mary A. Leavitt. Dr. Murlin, President of the University spoke glowingly of Boston University's past, present and future. Dr. John P. Sutherland, Dean of the Medical School, took as his theme the future of the Medical School. The standards of Boston University School of Medicine have always been high and they will always remain so. Practically all of the graduates of the School this year had academic degrees. One hundred and fifty-seven applicants for admission to the school this year, were refused admission, because their qualifications were not up to the standards maintained by the school.

Dr. Henry M. Polloch, Supt. of the Massachusetts Homœopathic Hospital, told of the busy year at the hospital. Co-operation with the physicians outside has been definitely sought. A standing committee of the Medical School meets with the executive committee of the hospital to work for co-operation and mutual assistance. The co-operation of the Alumni Association is a most valuable asset to the hospital. Dr. Sarah S. Winsor spoke of the remarkable career of Dr. Anna Howard Shaw (1886), in temperance, suffrage, medicine and public health. Dr. Shaw won her way up from the bottom of the ladder. She spoke all over our country, attracting every one to her by her remarkable magnetism, wit and faith in human kind. (A tablet is to be fittingly erected in



# Hay Fever Time

1920 JUNE 1920						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
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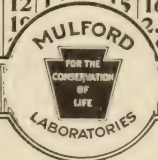
  

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1920 SEPTEMBER 1920						
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affected by the pollens of ragweed, golden rod, corn, etc., and subject to Fall Hay Fever, treatment is usually begun early—in July or August—at least four to six weeks before the expected attack.

Dr. W. Scheppegrell, Chief of the Hay Fever Clinic of the Charity Hospital, New Orleans, reports an analysis of 707 cases treated with pollen extract and vaccines, of which 89% showed satisfactory results, 4% showed little or no improvement, and 7% discontinued treatment before the result could be noted. In no case was there an aggravation of symptoms. (Public Health Reports, Vol. 34, No. 31, 1919.)

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the Medical School building, to Dr. Shaw's memory, by the Alumni Association.) Dr. Ray Spaulding, President of the senior class, pledged the enthusiasm and determination of the graduating class, to keep up the high standards set by the Medical School and to support her loyally and well. Dr. C. A. Eaton, the incoming President was presented and spoke with enthusiasm of the future of the Medical School and the Alumni Association. The last speaker of the evening was Mr. George W. Coleman of Boston, Mass. He gave a very enjoyable and scholarly address on "The Challenge of New Ideas."

The officers of the Association for the ensuing year are: President, Dr. Charles A. Eaton, (1908), 510 Commonwealth Ave., Boston, Mass.; First Vice-President, Dr. Charles T. Howard, (1898), 510 Commonwealth Ave., Boston, Mass.; Second Vice-President, Dr. Alice S. Woodman, (1903), 80 East Concord St., Boston, Mass.; Secretary, Dr. Cecil W. Clark, (1915), 306 Walnut St., Newtonville, Mass.; Treasurer, Dr. Howard Moore, (1905), 520 Beacon St., Boston, Mass.; Auditor, Dr. Milo C. Green, (1916), 19 Bay State Rd., Boston, Mass.; Directors, Dr. Mary A. Leavitt, (1902), 510 Commonwealth Ave., Boston, Mass.; Dr. Fred L. Emerson, (1892), 445 Marlboro St., Boston, Mass.; Dr. Clara E. Gary, (1885), 416 Marlboro St., Boston, Mass.; Dr. O. R. Chadwell, (1903), 793 Centre St., Jamaica Plain, Mass.; Dr. Harold Diehl, (1911), Greenleaf St., Quincy, Mass. Advisory Committee: Dr. George H. Earl, (1884), 1138 Boylston St., Boston, Mass.

Cecil W. Clark, M.D., Secretary.

**The 67th Annual Session of the New Jersey State Homœopathic Medical Society** was called to order by the President, B. H. Garrison, M.D., at 3:15 on the afternoon of Thursday, May 27, 1920, in the Assembly Room of the Chalfonte Hotel, Atlantic City. After the invocation by the Reverend Dr. Lucas, the minutes were read and approved.

The Treasurer submitted his report showing \$332.77 on hand. The Necrologist being absent the Secretary reported the deaths of Dr. Frank Nichols; Dr. Jacob Streets; Dr. G. Herbert Richards and Dr. Alfred Drury.

On motion, Dr. McGeorge was requested to write an obituary on Drs. Nichols and Streets, and the President was asked to appoint someone to write on Dr. Richards and Dr. Drury. There being no communications or bills, the President appointed Drs. J. H. Bryan, C. C. Straughn and L. N. Slaughter as the Committee on Nominations, and Drs. P. S. Kinne, Grover T. Applegate and Philip Krichbaum as Committee on Resolutions.

Notice of Amendment to the Constitution to make the Treasurer ex-officio a member of the Board of Censors, and to allow the Censors to elect members between sessions of the Society was given.

The following Amendments presented at the last meeting were finally passed:

1st. Article 1 of the Constitution shall read as follows: Name and Object. This Society shall be called the New Jersey State Homœopathic Medical Society.

Its objects shall be the same as those provided for by the Constitution of the American Institute of Homœopathy with which this Society is federated.

2nd. Article 9, Section 1 of the By-Laws shall be changed to read:

Arsenic and Mercury are Indispensable in the Treatment of Syphilis. We recommend

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Members shall pay annually, in advance, the sum of three dollars toward defraying the expenses of the Society.

3rd. Article 9, of the By-Laws, Section 5. There shall be paid from the Treasury of this Society, annually, into the Treasury of the American Institute of Homœopathy, the sum of one dollar for each member of this Association for every year, after the adoption of this amendment, for which his dues are paid, to be applied to the national propagandistic fund.

4th. Article 9, of the By-Laws, Section 2 add: "Such Physicians may however be reinstated by paying the dues in arrears, by a majority vote of the members present."

5th. Article 7, of the By-Laws, Add D Institute Committee, also add Sec. 5. The Institute Committee shall consist of two delegates appointed annually to the Congress of States of the American Institute of Homœopathy who must be members of the said American Institute of Homœopathy.

Their duties shall be to attend all meetings of the Congress of States, to have authority to act when the Society is not in session, to confer with the Executive Committee of the American Institute of Homœopathy and to have general supervision over Homœopathic matters in the state reporting annually to this Society.

There shall also be a 1st and 2nd Alternate Member of this Committee to act during any disability of a member of the Committee.

6th. Article 5 of the Constitution shall be amended to make the last phrase read: "Provided that notice of such alteration or amendment shall have been given to the members in writing at least thirty days before the meeting at which it is acted upon."

8th. Article 14 of the By-Laws shall be amended to make the last phrase read: "Provided that notice of such alteration or amendment shall have been given to the members in writing at least thirty days before the meeting at which it is acted upon."

Moved and carried that we invite the American Institute to meet in New Jersey next year.

The Censors reported favorably on the following men who were then elected to membership in our Society: Earl C. Lyon, Bridgetown; G. Louis Nichols, Hoboken; Newton H. Chaffee, Chesterfield; William Davis, Perth Amboy; William G. McCollough, Trenton; Albert G. Hullett, E. Orange; W. G. Herrman, Asbury Park; Clinton P. Sheaffer, Camden; S. Wesley Jack, Collingswood; William H. Morehead, Atlantic City; J. G. Savannah, Farmingdale; Paul A. Collins, Trenton.

The President's address was given on Friday afternoon. Dr. Thomas Youngman in the chair. Dr. Youngman appointed as the Committee on President's address: Drs. Hubbard, McKinstry and Maps.

Dr. W. A. Pearson of Hahnemann Medical College of Philadelphia, was elected an honorary member of our Society.

Notice was given of Amendments of By-Laws to add to the standing Committees a Committee on Printing.

The Committee on Revising the Constitution reported progress, and moved that a new Committee be appointed to carry on the work. Motion carried, and the President appointed as that Committee: Pres. Barrett, Sec. Brown, and Ex-Sec. Church.

Moved and carried that the President appoint a committee to work with the American Institute in advancing the program for Clinical Day. The President appointed: Drs. Hadley, Atkinson and Doremus.

Moved that the President make nominations for membership on the



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**CROSSEN—Diagnosis and Treatment of Diseases of Women.**—By H. S. Crossen, M. D., F.A.C.S., Associate in Gynecology, Washington University Medical School, St. Louis. 1160 pp., with 800 engravings: Fourth edition. Cloth \$8.00

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State Examination Board. Carried—he nominated: Dr. J. H. Bryan of Asbury Park; Dr. C. A. Groves of E. Orange and Dr. W. E. Doremus of Newark.

On motion, the Secretary was allowed to use his judgment in throwing away old papers.

The following recommendations of the Legislative Committee as presented by Dr. Bryan were then taken up:

On motion, the Society endorsed the plan of having the State pay the members of the Medical Examining Board \$250.00 per member per year.

On motion, the Legislative Committee was given power to act with the Regulars, Eclectics, Dentists and Pharmacists, to form a general Committee to help good legislation and hinder bad legislation on Medical subjects.

On motion, the Society endorsed the bill to require the annual registration of all doctors in the State at a fee of one dollar per year, and use the amount so collected for the prosecution of illegal practitioners.

The Nominating Committee reported the following nominations for the following year:

President, W. J. Barrett, of Camden; 1st Vice-President, Thomas Youngman, of Atlantic City; 2nd Vice-President, Harry S. Willard, of Paterson; 3rd Vice-President, J. W. Hughes, of Atlantic City; Recording Secretary, C. R. Brown, of Arlington; Cor. Secretary Sara Smalley, of Newark; Treasurer, L. N. Slaughter, of Pitman. Censors: L. N. Slaughter, for 1 year; S. R. Brown, for 2 years; Howard Ivins, for 3 years; H. H. Pettit, for 4 years; P. S. Kinne, for 5 years. Trustees: F. P. McKinstry, for 1 year; C. F. Hadley, for 2 years; J. H. Bryan, for 3 years; H. L. Maps, for 4 years; B. H. Garrison, for 5 years.

The Auditing Committee reported going over the books and finding everything correct. The Committee on the President's address made the following report:

The Committee on the President's address finds much to commend in his carefully prepared and clearly defined issues that entitles it to serious consideration. Yesterday's report of the Legislative Committee, and the action of the Society upon that report, somewhat forestalled the report of this Committee. However, it seems to be the duty of the Committee on the President's address, to make its report as originally agreed upon. The Committee approves and recommends that the Society adopt the suggestion that we combine and work together with other similar organizations to watch Legislation for our safety and protection.

We recommend the adoption of the proposition to have an annual Registration of all physicians, exacting a fee of \$1.00 each, and that such action be taken at this meeting.

We approve the suggestion that a Committee on Permanent Membership be appointed in each county. We heartily endorse the recommendation that a Permanent Board of Censors be elected in order that new members may be elected at any time during the year, and that the Secretary and Treasurer should be members of said Committees. We also endorse the recommendation that a Permanent Committee on Printing be appointed, and that the Secretary and Treasurer be members of the Committee. We endorse the proposition to have a Committee to revise the Constitution and By-Laws and that it report at our next meeting. We recommend the proposition of the American Institute that every

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Homœopathic Hospital set aside Oct. 19, as a National Homœopathic Clinical Day, and that a committee be appointed to secure the co-operation of our hospitals and aid the representation of the A. I. H. who shall be appointed to attend to the matter in this state.

A very enjoyable banquet was held in the Dining Room of the Chalfonte Hotel, Atlantic City, on Friday evening. After a regular Chalfonte Banquet, and there is no better, Dr. W. H. Fairbanks, of Freehold, took the gavel as toast-master, and introduced Mr. Raymond Schindler, of New York City, one of our greatest detectives, who spoke on the relation of Secret Service to the Doctors, and who held our attention while giving a very interesting and instructive talk.

Following, Dr. Fairbanks introduced Senator George Cartwright, of California, who gave us an address which we will not soon forget, on "The Mutual Interests of Labor and Capitol."

The following papers were presented during the meeting and were of an exceptionally high order and thoroughly discussed:

"Some Drug Affinities," by Wallace McGeorge, M.D., Camden.

"A Study of Gelsemium," by F. P. McKinstry, M.D., Washington.

"A Preliminary Report on Some Cases of Pulmonary Tuberculosis Under X-Ray Treatment," by William G. Herrman, M.D., Asbury Park.

"Tetanus," by L. E. Griscom, M.D., Camden.

"The Patient and Not His Disease," by Philip Krichbaum, M.D., Montclair.

"Fevers of Obscure Origin in Children," by C. S. Raue, M.D., Philadelphia, Pa.

"The Laboratory As an Aid in the Treatment of Children," by Henry B. Dorr, M.D., Ocean Grove.

"The Many Phases of Asthma, Etiologic and Therapeutic," by Clarence Bartlett, M.D., Philadelphia, Pa.

"The Early Recognition of Rheumatic Carditis," by William Rendell Williams, M.D., Philadelphia, Pa.

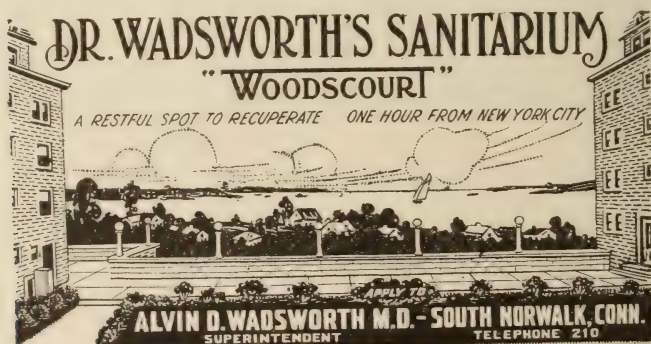
"Headache," by A. M. K. Maldeis, M.D., Camden.

"Hemolytic Streptococcus As an Infective Agent in the Human Economy," by Charles H. Hubbard, M.D., Chester, Pa.

The Committee on Registration and Statistics reported forty-six members, 9 visiting physicians, 22 non-medical visitors present during the meeting.

Respectfully submitted,

C. A. CHURCH, Secretary.



THE HAHNEMANNIAN MONTHLY  
NEWS AND ADVERTISER

A Medical Newspaper

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SEPTEMBER, 1920

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**Advanced Lessons in Practical Physiology**, for Students and Practitioners of Medicine, by Russell Burton-Opitz, M.D., Ph.D., Associate Professor of Physiology, Columbia University, New York City. Octavo of 238 pages with 123 illustrations. Philadelphia and London: W. B. Saunders Company, 1920. Cloth, \$4.00 net.

One of our old and highly esteemed teachers of bygone days, still active mentally and physically at a ripe old age, accounts for his freshness in part by his ever readiness to keep abreast of the times in the fundamental branches of medicine. Of physiology he says that it has been his custom for half a century to purchase a new physiological textbook once in five years, and read it through from cover to cover. The above fact was brought to our mind on looking over the pages of this book by Burton-Opitz, which has been written entirely with the idea of preparing the medical student for the clinical work of later years. With this end in view the subject matter has been presented in an eminently practical manner. Experiments which formerly constituted a large part of the physiological lecture, have been separated from the purely didactic subject matter and have been combined into a continuous course of practical exercise and demonstrations.

The author has embodied in these pages all those experiments which can be conveniently performed with the aid of simple apparatus. The lessons begin with muscles and nerves and gradually make greater and greater demand upon the experimental aptitude of the student. Those experiments which require complicated apparatus and may be more conveniently displayed to a larger number of students have been embodied in the demonstrations.

While preeminently a textbook for the class room, Burton-Opitz's book is one not beneath the attention of the practitioner of medicine who would keep abreast of the time in physiological lore.

**The Newer Methods of Blood and Urine Chemistry.**—By R. B. H. Gradwohl, M.D., Director of the Gradwohl Laboratories of Chicago and St. Louis, and Director of the Pasteur Institute of St. Louis. A. J. Blaivas, Formerly Assistant in Same; Formerly Assistant in Chemical Laboratory of St. Luke's Hospital, New York City. Second Edition. With 75 illustrations and 4 color plates. St. Louis: C. V. Mosby Company, 1920.

The old methods for the examination of urine still stand as of prime importance. Indeed it is doubtful if any future acquired knowledge will relegate them to the back-ground. The majority of these methods determine the diagnosis of advanced disease, oftentimes of organic and incurable character. Valuable though they have proven to be, enough has been known for a long time back to teach us that we cannot always depend upon them clinically for prognosis and treatment. Of late years many new tests have been devised, some of which have been proposed for their greater reliability, and others for determining the ability of the kidneys to functionate. In other words, there is a growing disposition to make functional rather than pathological diagnosis the real thing in medical practice.

There is a prevalent impression among physicians that these newer tests are difficult of application and comprehension. Some of them, it is true, do belong to this category, but there are many which are well within the capacity of a medical practitioner who possesses a moderately developed chemical technique.

Our authors have taken up the consideration of their subject-matter in a way that any physician can comprehend. They have placed within the pages of a single volume of less than 400 pages all of the tests at present accepted as reliable. They have not clouded their subject by presenting innumerable methods of procedure, but have rested satisfied with presenting one method only for each test, and that the one upon which they are accustomed to rely in their own laboratory work. In the chapters devoted to urinary examinations, we find instructions for determining total nitrogen, urea, ammonia, total acidity, uric acid creatinine, creatine, functional testing, or the staining of bacteria in the urine, etc.

Just as urine chemistry has shown its advances, so do we find the same as related to the chemistry of the blood. The latter subject has not been taken up by the profession generally with the enthusiasm its importance warrants. Nevertheless the time is not far distant when we must study the blood sugar in diabetics, and the nitrogen, creatine, creatinine, uric acid, urea, and non-protein nitrogen of the blood in the nephritics and in the metabolic diseases.

With Gradwohl's book at our disposal, there is no reason for the future neglect of these all-important investigations.

**Diagnosis and Treatment of Brain Injuries With and Without a Fracture of the Skull.**—By William Sharpe, M.D., Professor of Neurologic Surgery, New York Polyclinic Medical School and Hospital; Consulting Neurologic Surgeon, Manhattan Eye and Ear Hospital, Hospital for Ruptured and Crippled, Beth Israel Hospital, New York City, and Nassau Hospital, Mineola, Long Island, etc. 232 illustrations. Philadelphia and London: J. B. Lippincott Company.

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time religion." This was our thought as we looked over Sharpe's book on brain injuries. It is not that the author presents an entirely new line of thought, but that he has the courage to speak plainly concerning the value of a line of treatment that has been in vogue within small but select surgical circles, of which Hahnemann Hospital of Philadelphia has been one for the past 25 years.

The author gives his book the title of brain injuries with due thought as to the differentiation from skull fractures; a wise distinction, because the fatality and serious consequences of head traumatism depend upon the damage done to the brain itself. He lays special stress upon the importance of increased intracranial pressure as the important factor in the production of immediate symptoms, and of early and remote prognosis; and as a corollary of these, the necessity for prompt surgical treatment. His argument in a general way may be stated as follows: A thorough neurological and surgical examination, a close watching of the patient to note progress of symptoms, special attention to the phenomena of increased intracranial pressure, and the value of a subtemporal decompression as an efficient means of relieving the latter condition.

The author is very emphatic concerning the value of repeated ophthalmoscopic examinations at short intervals to discover what he accepts as a valuable guide of increased intracranial pressure, namely, a slight haziness of the fundi, becoming more and more evident with each inspection.

Dr. Sharpe does not decry the modern technical procedures, as X-ray, but is decidedly friendly to them; but like all thorough clinicians, he wishes no time wasted in waiting for them at the expense of neglecting clinical and obvious indications.

The subject-matter of the book is divided as follows: Part I, General Considerations; Pathology, Diagnosis and Treatment; Operative Technique. Part II, Brain Injuries in Adults; Illustrative Cases: (a) Acute; (b) Chronic. Part III, Brain Injuries in Newborn Babies and Children. Illustrative Cases: (a) Acute; (b) Chronic.

Illustrative cases are presented after the manner of the laboratory or research worker and serve as the protocol to prove the argument.

**Exophthalmic Goitre and Its Non-Surgical Treatment.** By Israel Bram, M.D., Instructor in Medicine, Jefferson Medical College, Philadelphia; Physician on Visiting Staff of Philadelphia General Hospital; Member of the Society for the Study of Internal Secretions, etc. St. Louis: C. V. Mosby Company, 1920. Price, \$5.50.

To cut or not to cut, that is the question, whether it is better to suffer the pangs of an outrageous goitre, or by the scalpel end them. And the question still remains, the cutters and the non-cutters being equally well satisfied that the opposing party in the controversy is virtually entirely in the wrong. Bram states with a conscientious positiveness that he believes exophthalmic goitre is a strictly medical disease, and then proceeds to outline the methods by which the treatment should be followed. He goes into extensive details concerning the varied elements involved, including general hygiene, rest, exercise, diet and feeding, mental hygiene, feeding of glandular extracts, indications, drugs, environment, electricity, etc. In fact, the author has left nothing concerning

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(Late First Assistant Physician at the Middletown State Homoeopathic Hospital, New York.)



the many factors entering into daily life unconsidered, for all of which he is to be praised.

We do not believe that he has given the X-ray treatment of exophthalmic goitre a fair consideration; in fact, so far as we can see, his review of the subject amounts to but little more than the quotations from authorities without any personal experience on the subject, or review of that of his co-laborers at Jefferson. The reviewer happens to be a firm believer in the value of the X-ray although not practicing X-ray therapeutics himself. He believes that the X-ray treatment should, whenever possible, be used before resorting to surgery.

It is over forty years since the reviewer has seen his first case of hyperthyroidism, and he has had opportunities of following cases over periods of many years. Until the advent of X-ray therapy he was rather inclined to state the prognosis of the disease rather tersely as "None are cured and few die." The late Dr. Musser made an extensive collective study of the medical versus the surgical treatment of exophthalmic goitre and showed that with each side selecting its cases, the mortality remained about the same for each. It would seem that the proper therapeutic position to assume is the following:

That the physician must differentiate his cases, and advise medicine or surgery according to indications, the latter involving not only the data relating to the disease, but also those pertaining to the patient himself and his environment. To adhere to the dictum that the disease is exclusively medical or surgical is wrong.

Bram's book is a useful guide for those who wish to follow strictly medical lines.

The publishers have adopted a sensible expedient advisable at all times, and independently of these days of paper shortage. The book is printed on a machine finished paper, substantial in body, and light in weight; easy for the eyes, and not tiresome to hold.

**The Duodenal Tube and Its Possibilities.** By Max Einhorn, M.D., Professor of Medicine at the New York Post-Graduate Medical School; Visiting Physician to the Lenox Hill Hospital, New York City. Octavo of 122 pages with 51 illustrations. Philadelphia and London: W. B. Saunders Company, 1920. Cloth, \$2.50 net.

A small book; an important one; written in an interesting style and as easily followed by the reader as are the fiction writers of eminence.

Our author has chosen to adopt the historical method of presenting the subject, beginning with the inception of the thought of the duodenal tube, and following out the development of various ideas and changes of ideas down to the present era. The simplicity of the whole thing causes wonderment, and we marvel that some one had not thought out the whole thing a long time before. As Einhorn presents the subject, the merest tyro can take up the practice of the duodenal tube where the masters have left off.

One thing is very certain, namely, that this little instrument has gained for itself the enviable position of being a necessary part of the medical equipment, without which the study and treatment of digestive disturbances becomes an impossibility.

We regret exceedingly that the author should have chosen to stop where he did; and that he did not continue his subject with reviews of the modern observations of other investigators along the same line, to-

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gether with such comments as may have appealed to him by reason of his vast clinical experience. Einhorn is the Nestor of American gastro-enterology, and the profession could have heard more from him with advantage.

The Regular Meeting of the Central Homœopathic Medical Society was held at the Hotel Columbia, in Columbia, Pa., on August 12th, at 12.30 P. M.

Dr. Harry Ursprung was proposed and unanimously elected to membership in the Society. Dr. Ursprung is from Lancaster.

The Committee on New Members reported work being done but that a spirit of indifference prevailed; one very difficult to overcome.

Dr. W. A. Pearson, a guest of the Society, then stated that the proper method of procedure was to accept all members into the State and National body right at the time of graduation. Dr. Piper, also a guest of the Society, then stated that continual plugging would necessarily get results.

Dr. Pilgram, Chairman on Exhibitors, for the coming State meeting then stated that \$600 had already been sold and that the difficulty in obtaining further spaces was very great but a final effort was to be put forth at once. Dr. Pilgram showed that he had done some work in this behalf.

Dr. C. M. Rhodes then reported that a very nice entertainment had been provided for the visiting physicians and their wives whilst in Harrisburg at the coming State meeting. It was further decided to hold no dance during the coming session.

The Committee on the Revision of the Constitution reported no action as yet.

Under new business Dr. Pearson gave a snappy talk about Hahnemann College and the showing Hahnemann graduates had recently made in State Board examinations. Dr. Pearson was in excellent mood.

Dr. Piper then addressed the members on the coming State meeting.

President Moyer then appointed the following committee as a Reception Committee for the State meeting: Dr. Hartman, Chairman; Dr. Sayres, Dr. Snyder, Dr. Stitzel and Dr. Read.

Dr. Snyder, of Lancaster, then re-read his paper on "Health Insurance," an excellent thesis. Discussion was lively and indulged in by all present.

Dr. Noll then read a paper on "Medical Economics." This paper was well written and timely in character. A good discussion followed.

Dr. W. C. Seitz then presented a snappy and interesting brief of the meeting of the American Institute of Homœopathy in Cleveland session. He gave the members the gist of all the proceedings at the last meeting. In closing Dr. Seitz did not hesitate to disclose just who was and who was not a member of the A. I. H. in the Central Society.

Dr. Sayres then moved that the next meeting be held in Harrisburg on the National Homœopathic Clinic Day before the clinic at the Keystone Private Hospital. This motion was seconded and passed unanimously.

It was then moved and seconded that Dr. Piper be elected to honorary membership in the Society. Dr. Piper was elected unanimously.

The President then ordered that the Secretary act as a Publicity



## Quotations from Doctors: No. 6

“When the cervix is red, eroded and indurated, when ulcerations are present, accompanied with thick, tenacious discharge; in acute and chronic endometritis; in ovarian, uterine and vaginal inflammations, the liberal use of



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R. A. V., M.D.

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Committee of one to make public the National Homœopathic Clinic Day on October 19, 1920.

Twenty members attended and a most enjoyable spirit prevailed.

H. M. Read, Secretary-Treasurer.

**National Clinic Day at Hahnemann Hospital of Philadelphia.**—Dr. Clarence Bartlett has been appointed Chairman at Hahnemann Hospital, Philadelphia, for the National Homœopathic Clinic Day, October 19, 1920. Two sections of clinics will be operated simultaneously for the day, starting at 9 A. M. and closing at 5 P. M. These clinical sections will be medical and surgical respectively. The surgical section will be in charge of Dr. H. L. Northrop, and will include not only general surgery but the various surgical specialties, the program of which will be announced in the next issue of the Hahnemannian Monthly. The medical section has provided for clinics and demonstrations by Drs. Clarence Bartlett, O. H. Paxson, C. Sigmund Raue, G. Morris Golden, W. R. Williams, G. Harlan Wells and Ralph Bernstein.

**National Homœopathic Clinic Day at Reading.**—Dr. D. C. Kline has been appointed chairman for "Clinic Day" at the Reading Homœopathic Hospital. A meeting of the homœopathic physicians of Reading was held Tuesday evening, August 10th, as a result of which the following tentative program was formulated: Dr. C. R. Haman, with Drs. Geo. R. Curry and Geo. W. Krick will have charge of the surgical clinics. Dr. Ed. K. Golding will give a genito-urinary clinic with instructions on this subject. Dr. A. S. MacDonnell, assisted by Dr. T. F. Erdman will present a series of gynaecological cases and operations. Dr. R. C. Klopp and Dr. Paul H. Gerhardt the eye, ear, nose and throat section. Dr. H. H. Lewis will likely present several marked cases of skin lesions and give direction for prescribing and treating the patients. Dr. D. C. Kline and Dr. M. Hassler will hold a paediatrics clinic, presenting a number of interesting children with unusual or peculiar diseases. Dr. W. A. Haman will present numerous interesting X-ray plates. Other features may be added.

**American Association of Orificial Surgeons.**—The 33rd Annual Convention and Clinics of this Association will be held at Chicago on October 4th to 6th, inclusive. The headquarters will be at the Lexington Hotel and the Fort Dearborn Hospital. Physicians generally are invited to be present, and become members. The secretary of the Association is Dr. G. Schmidt, Lake City, Minnesota.

### PERSONALS.

Dr. William W. Van Baun has left Philadelphia for an extended period of rest in California. He expects to return in about a year, during which time his practice will be continued by Dr. B. K. Fletcher.

Dr. H. D. Conley has been appointed to deliver the lectures on "Principles of Dietetics" in the Hahnemann Medical College of Philadelphia.

Dr. Thomas Matlack has been appointed to deliver a course of lectures on "Industrial Medicine and Surgery" at the Hahnemann Medical College, of Philadelphia.

Dr. John A. Brooke wishes to announce that he has associated with him, Miss Marion Bryant, an experienced Masseuse and Medical Gymnast, who will assist him in his orthopedic work, pay particular attention to the treatment of Spinal Curvature and be able to give the necessary early



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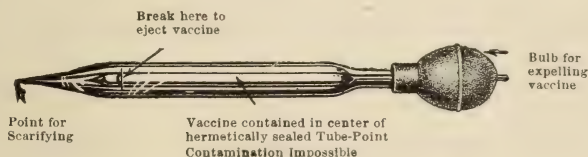
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Dr. Sutherland's office will be closed from August 7th to September 7th, while he is absent on a short trip to The Hague attending meeting of International Homœopathic Council.

**Pennsylvania State Society Notes.**—Our genial friend Dr. William Raymer of Beaver Falls promises 100 per cent. attendance at Harrisburg of the Beaver County Homœopathic Medical Society. If all of our men and women are as young in spirit and loyal in action as Dr. Raymer our meeting will break all records.

Dr. Pilgram of Harrisburg, Chairman of the Exhibit Committee already has a fine list of exhibitors signed up and more to follow.

The North-Eastern section of the State represented in part by Scranton, Reading, and Wilkesbarre, are enthusiastic and will be in Harrisburg in force.

Quite a number of the Pittsburgh men expect to enjoy the trip by auto via the Lincoln Highway.

Tuesday evening's session will be devoted to social enjoyment and a discussion by prominent speakers of the proposed Health Insurance Measure. The Committee appointed by the Governor expect to favor us with their presence.

Your President will be greatly disappointed if we do not have the largest and most enthusiastic meeting we have held for ten years. Homœopathy is more honored and respected in America than ever before. It's up to us to make good.

R. L. Piper, M.D., President.

**Entertainment Features in Connection with September Meeting of Homœopathic Medical Society of the State of Pennsylvania.**—Members: Tuesday evening, 10 P. M. Smoker following meeting on Health Insurance. Wednesday evening, 7 P. M. Banquet at Hotel Penn-Harris.

Ladies: Tuesday 4 P. M. Tea at Civic Club. Tuesday evening Entertained by Local Committee. Wednesday 11 A. M. Visit to State Capitol. Wednesday 2:30 P. M. Auto ride to Hershey and Tour through Hershey Chocolate Works. Wednesday 7 P. M. Banquet with Members at Hotel Penn-Harris.

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## COLLEGE NOTES

The Hahnemann Medical College and The Hahnemann College of Science will be formally opened on Monday evening, September 27th, at 8.30 o'clock.

A large number of splendid young men have been enrolled and everything looks favorable for another successful year.

The Senior Class is as large as we can properly accommodate and every member of this class will work hard to demonstrate that he deserves to be graduated from "The Best Medical College in the World." During the week of October 11th this class will study mental diseases at Allentown State Homœopathic Hospital under Dr. R. I. Klopp and his able staff of experts.

The Junior and Sophomore Classes will have the benefit of much

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personal attention. A number of the Sophomore Class are now working on their thesis which must be presented and approved before they can be given their degree of Bachelor of Science.

The Freshman Class will include not only most of the class who took our second year science course last year, but in addition, several very high grade college men who are anxious to obtain a comprehensive medical education.

The Hahnemann College of Science will have the maximum number of students we can properly accommodate and a number of important improvements have been made in the course.

Dr. George Stewart and Dr. William Speakman have been in Europe this summer and a number of other faculty members have been doing special work.

Dr. J. H. Hepburn will be a full time man in the Department of Chemistry and will devote a considerable portion of his time to research work for which he is exceptionally well qualified.

Dr. Herbert G. Kribbs will have charge of the work in Biology. Dr. Kribbs is a teacher of ability and experience and has done a large amount of work in the Wister Institute of Anatomy.

Every Hahnemann man who took recent examinations for licensure in Pennsylvania, Maryland, Delaware, Virginia, Ohio and Connecticut, passed. No reports have been received from other States. Dr. Charles Defeo obtained the highest average of any candidate in Connecticut.

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#### DEATHS.

Charles Henry Struble, of Dayton, Ky., a graduate of the Pulte Medical College, 1895; aged 47 years; Captain, M. C. U. S. A., discharged December 26, 1918; died, July 19, after a surgical operation.

Robert B. Jenks, M.D., Yonkers, N. Y., a graduate of the New York Homœopathic College, 1868; aged 75 years; died July 19th, from heart disease.

James S. Bell, M.D., Oak Park, Illinois; a graduate of the Homœopathic Medical College of the State of New York, New York City, 1866; aged 79 years; died August 8th, of senile debility.

Maria Brown Averill, M.D., San Diego, California; a graduate of the Hahnemann Medical College of the Pacific, San Francisco, 1889; aged 85; died, July 7th.

John Frank Peterman, Lebanon, Pa., a graduate of the Hahnemann Medical College of Philadelphia, 1866; a member of the American Institute of Homœopathy and of the Homœopathic Medical Society of the State of Pennsylvania. Died of pneumonia, July 25th.

Caroline Mary Smith, M.D., of Milford, Conn.; graduate of the New York Hospital and Medical College for Women, 1895; aged 80 years; died May 12, from heart disease.

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**Pennsylvania State Board Questions.**—Surgery, Anatomy: 1. Give three widely different conditions in which retention of urine may occur. (a) Discuss the cause in each condition selected. (b) Indicate the proper method of relief in each case. 2. In what three different types of disease may intestinal obstruction occur? (a) Discuss the cause in each type. (b) Indicate the proper method of relief in each. 3. Indicate (a) the various complications which may follow middle ear disease, (b) the stage of the ear disease in which each is threatened, (c) the necessary steps by which one may anticipate and prevent the disease and its com-



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plication. 4. Indicate the usual effect of meningeal hemorrhage at various points. Can the diagnosis be made from cerebral thrombosis? If determined in the affirmative, indicate the differential points. 5. Discuss in full detail the handling of a case of a possible perforating wound of the abdominal wall. 6. Discuss in full detail the handling of a perforating wound of one of the extremities. 7. Mention five different types of possible hemorrhage. Indicate the proper method of control in each instance. 8. What are the possible resulting conditions in the case of a man whose head has come into violent contact with a foreign body? Indicate the differential diagnostic points as well as the treatment in each case. 9. When an acute local disturbance develops in an old inguinal hernia, indicate the possibilities of the source of the trouble, together with any anatomical or pathological changes which may have taken place. In a general way state the indicated methods of relief. 10. Given an attack of acute abdominal disturbance, mention five possible conditions which may be the cause. Briefly give the distinguishing differential points in diagnosis.

Diagnosis, Symptomatology, Toxicology, Medical Jurisprudence: 1. Discuss the causes of increased frequency of urination in a male. 2. Discuss the suggestive evidence of syphilis of the heart and circulatory system. 3. Give the early symptoms and physical signs of lobar pneumonia. Differentiate it from broncho-pneumonia in its early stage. 4. Give the principal causes of convulsions occurring in early childhood. 5. In an adult patient with a swollen, slightly tympanitic abdomen, mild diarrhea, temperature not above 101 degrees, sick not more than two or three days, how would you differentiate between a possible typhoid fever and appendicitis? If your diagnosis were appendicitis, under what conditions would you advise possible operation? 6. Discuss the value of roentgenology in the diagnosis of diseases of the stomach and duodenum. Describe briefly the technic of such examination. 7. What is meant by focal infection? Where do foci of general and of local infection most frequently develop? 8. In a case with delirium in which no history is available, how would you differentiate clinically and otherwise between a possible cerebro-spinal fever and typhoid fever? 9. Differentiate circumstantial testimony from fact testimony. 10. What are the symptoms of acute poisoning by wood alcohol? What is the treatment for such poisoning?

Obstetrics, Gynecology, Physiological Chemistry: 1. A primipara presents herself for a prospective delivery; (a) How would you determine that a normal delivery will ensue? (b) Detail the results of your findings and deductions. 2. Describe in detail the changes which take place in the uterine mucous membrane to prepare it for the reception of the fertilized ovum. Describe the process and the final product of this change. 3. Outline the management of a patient during gestation and for a period of two months after delivery. 4. What conditions of the pregnant woman would lead you to suspect a potential eclampsia? Outline a preventive plan of management. 5. Upon what findings would you base a diagnosis of a transverse position? Detail the management of the delivery. 6. What signs and symptoms would lead you to suspect a case of salpingitis of the right side? Differentiate three conditions which might be mistaken for it. 7. Discuss a possible cause of post-partum insanity and outline its management and treatment. 8. Detail the conditions which would justify a curettage of the uterus. Specify contra-indications. 9.



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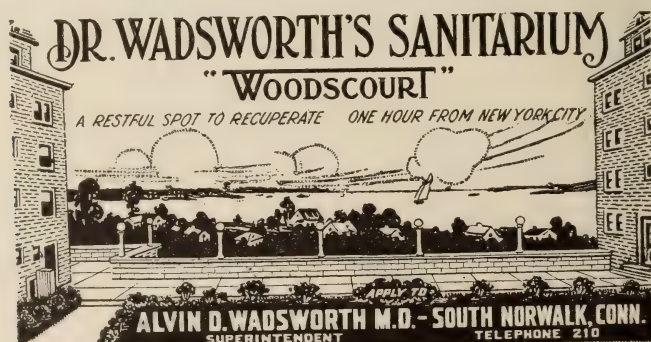
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Explain the important relation of haemoglobin to the function of respiration. 10. Describe various kidney functional tests and give the significance of the findings.

Physiology, Pathology, Bacteriology: 1. Name five bacteria stating briefly how each may be identified. 2. Explain why there is loss of weight in: (a) diabetes mellitus; (b) pulmonary tuberculosis. 3. Outline the pathological sequence by which diseased tissue in the throat may lead to acute mastoiditis. 4. Select a reflex arc and indicate its normal function. Describe a pathological lesion which may alter its function. 5. Explain the disturbance in function: (a) in glaucoma; (b) in exophthalmic goitre. 6. Describe the following lesions and indicate their clinical significance; (a) aneurysm; (b) varicose veins; (c) urethral stricture; (d) ulcerative endocarditis. 7. Describe briefly the physiologic and pathologic changes in (a) gastric carcinoma; (b) acute parenchymatous nephritis. 8. During gestation, what laboratory investigations, (a) would secure safety to the mother? (b) would enhance the welfare of the prospective child? 9. Discuss briefly pneumonia in relation to physiology, pathology and bacteriology. 10. What principles are involved, (a) in the Wassermann reaction? (b) in autogenous vaccine therapy?

Practice, Materia Medica and Therapeutics, Hygiene and Preventive Medicine: 1. Name three diseases subject to occupational influences and outline preventive measures that might be instituted. 2. Outline, (a) the hygienic, (b) the palliative and (c) the curative treatment of bronchial asthma. 3. What treatment would you apply to a patient giving a history of lack of appetite, general gastric distress with a sense of weight and tenderness in the epigastrium; gastric and intestinal fermentation, associated with underweight and a condition of general weakness? 4. What measures should be taken to prevent the occurrence of syphilis? Of consumption? Of diphtheria? How may tetanus be prevented. 5. Name the active principles on which the following named drugs mainly depend for their therapeutic action and give the maximum dose you would consider safe in the administration of each. (a) Aconite; (b) Belladonna; (c) Nux-Vomica; (d) Opium; (e) Aspidium. 6. Write a prescription applicable in the treatment of: (a) gonorrhea; (b) chronic constipation; (c) arterio-sclerosis with high blood pressure. (Metric system preferable.) 7. Outline the management of a case of pneumonia. 8. Name the principal contra-indication in the use of: (a) Salicylates; (b) Opium; (c) Heart Depressants. 9. What remedies and other means might be safely resorted to in the reduction of overweight associated with increasing blood pressure? 10. Outline the principal value of massage and hydrotherapy as therapeutic measures.



THE HAHNEMANNIAN MONTHLY  
NEWS AND ADVERTISER

A Medical Newspaper

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OCTOBER, 1920

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**International Clinics.** A quarterly of illustrated clinical lectures and especially prepared original articles on treatment, medicine, surgery, neurology, paediatrics, obstetrics, gynaecology, orthopaedics, pathology, dermatology, ophthalmology, otology, rhinology, laryngology hygiene, and other topics of interest to students and practitioners, by leading members of the medical profession throughout the world. Edited by H. R. M. Landis, M.D., Philadelphia, U. S. A. with the collaboration of Charles H. Mayo, M.D., Rochester; William S. Thayer, M.D., Baltimore; Hugh S. Cumming, M.D., D.P.H., Washington; Frank Billings, M.D., Chicago; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; Charles Green Cumston, M.D., Geneva; John Foote, M.D., Washington, D.C. With correspondents in Montreal, London, Paris, and Geneva. Volume II. Thirtieth Series, 1920. Philadelphia and London: J. B. Lippincott Company, 1920.

With this issue of the Clinics is announced a new department, that of Industrial Medicine, most assuredly one of great value. At the present time, this branch of professional work has become one of the greatest importance as an exclusive specialty to which increasing numbers of physicians apply themselves each succeeding year. Two motives have actuated this crusade from general practice, namely, the limitation of work to strict business hours (the 8 hour day of the labor unions) and the good salaries with freedom from overhead and carrying business expenses.

The editors of this department are Paul B. Magnuson, Medical Director of the Illinois Industrial Commission, and John S. Coulter, surgeon of the Indiana and Illinois Coal Corporation. Their first con-

tribution to "The Clinics" is quite lengthy, but embraces descriptions with running comments of a variety of cases; so that in reality their communication is made up of a number of individual clinical reports, all of which go to show the immensity of "Industrial Medicine."

This number of the Clinics also presents the usual collections of essays and clinical lectures bearing upon general medicine, surgery and the specialties, matters always of interest.

We were amused at the use of the designation of "Eccyesis" for ectopic pregnancy; and most assuredly we sat up and took notice. We object to additional confusion of medical nomenclature by the introduction into general literature of seldom used terms. Eccyesis is etymologically correct; any one who has been a reader of literature, recognizes the meaning of the word at once; but for years, we have so constantly used the terms "ectopic pregnancy," "extra-uterine pregnancy," etc., that eccyesis appears to us as bordering on pedantry.

**Studies in Neurology.**—By Henry Head, M.D., F.R.S., in conjunction with W. H. R. Rivers, M.D., F.R.S., Gordon Holmes, M.D., C.M.G., James Sherren, F.R.C.S., Theodore Thompson, M.D., and George Riddoch, M.D. In two Volumes. Volume I. London, Henry Frowde, Oxford University Press; Hodder & Stoughton, Ltd., Warwick Square, E. C. 1920. Price, \$17.00.

Students of neurology as well as medical practitioners generally have taken great interest in Head's investigations of the peripheral nervous system, which covered so many years. These articles have appeared at irregular intervals in the medical journals, mainly, however, in *Brain*, a standard journal whose circulation, however, was limited mainly to neurologists. Necessarily, then, Head's articles were not accessible to general practitioners, or, indeed, to the newer line of neurologists. It is very gratifying therefore to find this entertaining series of reports of investigations brought together in two handsome volumes, thoroughly edited and brought up to date.

Head's studies in Neurology are not fit subjects for light reading; nevertheless, the fact is that the author's style of diction is both excellent and fascinating; idea follows idea; one fact is put forth after another; no words are wasted. In other words, the author writes like a man who has positive ideas and knows the things about which he is talking.

Taking Head's conclusions, which appear to the reviewer to be based upon a logical foundation, and comparing them with the teachings of fifteen or twenty years ago, we are convinced that we must recast entirely much of our knowledge concerning the localization of function in the various constituents of the nervous system. To the neurologist, the book is an absolute necessity; to the practitioner, it will be of value or not according to the interest which he takes in nervous troubles or in a logical course of clinical study and investigation.

**Medical Therapeutics for Daily Reference.**—Edited by R. F. Rabe, M.D. Authorized by The American Institute of Homœopathy. Boericke & Tafel, 1011 Arch Street, Philadelphia, Pa. Copyright 1920. 280 pages. Price \$1.25 net, (postage extra.)

This volume has been prepared, with the official approval of the American Institute of Homœopathy, in response to a demand for authoritative and concise information in regard to the principles and practice





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of Homœopathy, on the part of physicians who have not had the opportunity of acquiring this knowledge during their medical course.

The idea then on the part of the Institute was to secure the publication of a concise hand-book presenting the more reliable and better-known indications for commonly used remedies.

Doctor Rabe is so well known by reason of his addresses at our Society meetings and of his contributions to our literature that any of our readers acquainted with his talents in either of the above directions can understand at once the thoroughness and efficiency with which the task has been completed.

**The Sympathetic Nervous System in Disease.**—By W. Langdon Brown, M.A., M.D. (Cantab.), F.R.C.P. (Lond.) Physician with charge of Outpatients, St. Bartholomew's Hospital. Physician to the Metropolitan Hospital, etc. London, Henry Frowde, Oxford University Press; Hodder & Stoughton, Ltd., Warwick Square, E.C. 1920. Price \$4.25.

Almost invariably when we have picked up a dissertation on the sympathetic nervous system we have lost our patience because dissertations of this character are commonly an avalanche of verbiage and a paucity of ideas. It can hardly be expected therefore with these prevailing ideas that we take up Doctor Brown's book in any charitable spirit. As it happened, we started and we read the preface and we kept on reading until we did what we seldom have done—read the book from cover to cover.

The book itself is based upon the Croonian lectures delivered before the Royal College of Physicians in London in 1918. It does not attempt to give a detailed account of the anatomy of the autonomic or vegetative nervous system. Rather it aims to emphasize the main plan of that system which is, after all, very simple.

The book is made up of seven chapters, as follows:

The Plan of the Autonomic Nervous System. The Sympathetic Nervous System in Relation to the Endocrine Glands. The Sympathetic Nervous System in Relation to Glycosuria. Diseases of Digestion. Diseases of the Circulatory System. On Vagotonia. The Responses of the Sympathetic Nervous System.

Those which interested us the most were the three relating to the endocrine glands, diseases of digestion and diseases of the circulatory system. However much the reader may agree or disagree with the author, one thing to us is certain, that he becomes a better physician and a better thinker by reason of having read Langdon Brown's book.

**Functional Nervous Disease.**—An Epitome of War Experience for the Practitioner. Edited by H. Crichton Miller, M.A., M.D. Formerly Medical Officer in charge Functional Cases, No. 21 General Hospital, Alexandria. Late Consulting Neurologist, 4th London General Hospital. London, Henry Frowde, Oxford University Press; Hodder & Stoughton, Ltd., Warwick Square, E. C. 1920. Price \$4.50.

While this book is based upon war experiences and apparently gives the impression to the reader that it is a war book, in reality it is simply a review of the war neuroses and their treatment with a rational study of the subject as applied to both war and civil practice.

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C. SPENCER KINNEY, M.D.,

(Late First Assistant Physician at the Middletown State Homoeopathic  
Hospital, New York.)



**Infectious Diseases, a Practical Textbook.**—By Claude Buchanan Ker, M.D., Ed., F.R.C.P. Ed., Medical Superintendent, City Hospital, Edinburgh, and lecturer on infectious diseases to the University of Edinburgh, Major, R.A.M.C., T.F. Second Edition. London, Henry Frowde, Oxford University Press; Hodder & Stoughton, Warwick Square, E.C. Price, \$17.00.

When the first edition of Ker's book on Infectious Diseases appeared in 1914, it took first rank among English-speaking physicians as authority on infectious diseases, equalled by scarcely more than one or two works in this country and excelled by none anywhere. Quite naturally, a second edition was demanded, but its publication was necessarily deferred because of the trials and tribulations of the book business incidental to the World War. The author admits that twice within the past six years he has been obliged to revise his manuscript, waiting upon his publisher.

The large amount of work which has been done on the subject of infectious diseases during the last ten years has necessitated extensive alterations and additions, and several portions of the book have been entirely rewritten. To make room for new matter, the chapter on relapsing fever has been omitted and the sections on bacteriology and pathology have been reduced to the lowest possible limits.

The book is very largely a record of personal experience. It is unfortunate that the author has found it impossible, by reason of the many trying circumstances to which all of us have been obliged to submit, to try out with the vast material at his command the innumerable new ideas in the realm of therapeutics. Doctor Ker has therefore seen fit to mention such innovations as appeal to his judgment as being worthy of professional confidence.

The volume is one of unusually artistic construction, with large page, legible type, machine-finished paper embellished with numerous illustrations, both in black and white and in colors.

**The Oxford Medicine.**—By various authors. Edited by Henry A. Christian, A.M., M.D., Hersey Professor of the Theory and Practice of Physic, Harvard University, Physician-in-Chief to the Peter Bent Brigham Hospital, Boston, Mass., and Sir James MacKenzie, M.D., F.R.C.P., LL.D., F.R.S., Consulting Physician to the London Hospital, and Director of the Clinical Institute, St. Andrews, Scotland. In Five Volumes, illustrated. Volume I. The Fundamental Sciences and General Topics. Oxford University Press, American Branch, 35 West 32nd Street, New York. London, Toronto, Melbourne, Bombay.

Somewhere we recall having seen a picture of a child grasping for something and beneath, the legend lines, "Now that he has it, what will he do with it?"

For many years, it has been the fond desire of doctors as well as many others to have text books to which additions or subtractions could be made in accordance with the progress of science and so avoid the great expense of buying new editions year after year. In other words, there was a demand for what might be called an "elastic" text book. Thus originated the idea of a loose-leaf medicine.

The Oxford University Press have undertaken at last to supply this long-felt demand and we wonder, now that the profession has been given

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the opportunity, whether it will be appreciated or not; whether it will support the publishers in what is evidently a very expensive venture.

The fasciculi, which originally comprised the present volume, made a total of 635 pages. Since they were published, additions have been made to Volume I, so that now we find included therein 915 pages. In other words, this loose-leaf medicine of the Oxford people has been undertaken with seriousness of purpose and determination to deliver the goods. We have already reviewed this volume in loose-leaf form and have expressed in unmistakable terms the interest that we have taken and the pleasure derived in reading it.

**The Treatment of Syphilis.** By H. Sheridan Baketel, A.M., M.D. Fellow of the American College of Physicians; Lt-Colonel, Medical Reserve Corps, United States Army; Professor of Preventive Medicine and Hygiene and Lecturer on Genito-Urinary Diseases and Syphilis in the Long Island College Hospital, Brooklyn; Attending Syphilologist and Chief of Clinics, Volunteer Hospital, New York; Genito-Urinary Surgeon to the House of Relief of the New York Hospital; Medical Director of the H. A. Metz Laboratories; Member of the American Urological Association, etc. New York: The Macmillan Company, 1920.

This volume has not been written for the skilled syphilographer who is thoroughly familiar with his subject, but is intended particularly for those physicians whose acquaintance with intravenous therapy is limited. For this reason, detailed description of the preparation and injection of salvarsan is elaborately given.

However the whole subject of the treatment of syphilis is discussed in detail, the Wassermann reaction, the application and effects of the mercurials and iodides, while the indications and contra-indications of the various methods are discussed.

The book is plainly written, the illustrations are good and the entire question of how to treat this common disease is given in such an interesting, concise and lucid manner that any physician will be well repaid by its perusal.

**Annual Meeting of the Southern Homœopathic Medical Association; Special Invitation to Its many Friends in the North and East; A Record Meeting in Prospect.**—Extensive preparations are well under way for the annual meeting of the Southern Homœopathic Medical Association, which will be held at Richmond, Virginia on November 17-18 and 19. Headquarters will be at the Jefferson Hotel. The Association has ample reason to believe that according to its usual form, an interesting, well attended meeting is in prospect.

The Trustees of the Association take this means to invite to the Richmond meeting, all members of our School in the east and north. This time the Southern will meet farther south than for some years. Important gatherings of this kind serve to spread knowledge of our school over a wide territory adjacent to the meeting place. In recent years, public meetings have been a strong feature of these Southern Association gatherings, and local laymen have thus been afforded a good opportunity to learn more regarding Homœopathy. This year the same plan will be followed, and to insure success throughout these sessions,



## Quotations from Doctors: No. 7

“The majority of cases of pneumonia, in my experience of thirty years’ medical practice, have had more or less pleuritic complications.

“I presume this is the experience of my colleagues.

“The most grateful application that can be made to a patient suffering with pneumonia is a warm



poultice under a moderately firm binder or jacket. Its action is, first through the superficial vessels, and then more slowly but just as efficiently on the deeper congested parts.”

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we shall need the presence of our best people to help produce the strongest possible program of essays and discussions.

To the east and north, Richmond is more accessible than were the meeting places of recent years. Distance did not deter the doctors in that section from attending in the past. We hope that this year, however, in view of the shorter traveling distance, a larger number than ever will come to us from the various homœopathic centres east and north. Many of our people all over the country have signified their intention of coming to the Richmond meeting. A wide area is represented on the program, and we doubt not that the attendance will be composed of our doctors from many states.

The program bids fair to be strong, one of the most attractive and most instructive programs that the Southern has ever put forth. Many of the national committees have been called to meet during these sessions, thus increasing the attendance and drawing many national leaders to the meeting.

Virginia and the south compose a fertile field for Homœopathic activities. Many young people from that section will be attracted to our colleges as knowledge of Homœopathy and of the excellent training facilities in those colleges are made known. In behalf of all projects to be presented at the Southern meeting and to help the Association maintain its record of a better program each year, we earnestly solicit the attendance of our doctors in the great section which is the special field of this magazine, the Hahnemannian Monthly, whose editor has graciously accorded space for our invitation to its readers.

H. M. Stevenson, M.D., Secretary.

**For Sale.**—In a Rhode Island city, a practice; collections \$10,000 to \$12,000 per year. Thirty years in the same office. For further information, address, "W.," care of Hahnemannian Monthly, 1435 Spruce Street, Philadelphia, Pa.

**National Clinic Day in Pennsylvania.**—Dean Pearson, who is State Chairman for National Clinic Day in Pennsylvania, called a meeting of the various hospital chairmen in connection with the meeting of the State Society at Harrisburg. All the hospitals were represented. Dr. Bartlett, representing Hahnemann Hospital of Philadelphia spoke first, and announced that two sets of clinics running simultaneously from 9 A. M. to 5 P. M. would be given. Dr. Northrop has been appointed sub-chairman to arrange for the surgical clinics, the speaker arranging the programme for the medical. He also suggested the advisability of sending out formal invitations to all physicians within a radius of 50 miles. He offered the suggestion that the small hospitals located in sparsely settled territory where there were but few physicians should make it a point to hold clinics on matters that interested the general public, as "mothers' clinics," "child welfare," etc. Dr. Moreland spoke for the Pittsburgh Hospital, and he and Dr. Calhoun, had a good programme in hand, including a dinner and address for the public in the evening. Dean Burritt, of Columbus, announced that the Clinics in Columbus, Ohio, had already been planned by the hospital staff, and their publication in the Central Journal of Homœopathy was assured. Dr. T. A. McCann made a few remarks of general character bearing on the importance of the occasion. Dr. Kline spoke for Reading, Dr. Robert White, for Scranton, Dr. Krusen, for Norristown, Dr. Hartmann, for Harrisburg. Clinics were announced for other of our Pennsylvania Hospitals, but as their chairmen were



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Arrangements have been made to include instruction in and practical application of the various forms of anesthesia for a period of three months. No fee for the course will be made, each student receiving board, room and laundry during the period of her stay. In certain instances an additional period of three months can be arranged for instruction in x-ray technique. All applications should be addressed to Dr. H. M. Pollock, Supt., Massachusetts Homœopathic Hospital, Boston, Mass.

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#### DEATHS.

Virgil Thompson, New York; New York Homœopathic Medical College, New York, 1862; died May 28.

Eva Harding, Topeka, Kan.; Hahnemann Medical College, Chicago, 1882; aged 62; died, July 27, from heart disease.

Edwin Herbert Russell, Los Angeles, California; Boston University, School of Medicine, 1880; aged 63; died July 16.

Cornelius W. Cramer, Pentwater, Mich.; Hahnemann Medical College, Chicago, 1886; for forty-five years a practitioner; died about July 12.

Charles C. Williams, Pittsburgh; Cleveland University of Medicine and Surgery, 1894; aged 48; a veteran of the war with Spain; died July 21st.

Louis B. Carson, graduate of Hahnemann Medical College, Chicago, 1892, died at the age of 47, from heart disease on March 10, at his home in Maquoketa, Iowa.

William Ralph Buchanan, graduate of Hahnemann Medical College, Philadelphia, 1902, died at the age of 49 on March 5, at the Walter Reed General Hospital, Takoma Park, D. C., while undergoing physical reconstruction.

Ernest Major Jordan, graduate Boston University, 1899, died at the age of 48, on March 13th from pernicious anemia at his home in Boston.

Archie B. Atchison, graduate of Hahnemann Medical College, Chicago, 1899, died at the age of 78 on March 8th, at Irvington, Ala., from heart disease following influenza.

Edward Horace Spooner, Park Ridge, N. J., New York Homœopathic Medical College, New York City, 1869; aged 81; a veteran of the Civil War; also a clergyman; died May 30.

Horace S. Hutchins, Batavia, N. Y.; Homœopathic Medical College of the State of New York, New York, 1861; aged 91; died May 28, from broncho-pneumonia.

Arsenic and Mercury are Indispensable in the Treatment of Syphilis. We recommend

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powerful and easily administered spirocheticides, which are as efficacious as the imported products,

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put up in COLLAPSULES (compressible ampules), which insure accuracy of dosage with a minimum of pain after intramuscular injection.

This combination of anti-luetics has no superior in the therapeutic field. Literature upon application to

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heat depression—with its impairment of the appetite, digestive troubles, bowel disturbances, diarrheal disorders, nervous exhaustion, cardiac embarrassment and deranged functions—generally,—can be effectively relieved, and often prevented, by the use of

## **Gray's Glycerine Tonic Comp.**

Two to four teaspoonfuls in iced water or poured over cracked ice will not only greatly refresh invalid or convalescent patients to a gratifying degree, but its continued use will substantially increase the vital resistance. The effect on the appetite, digestion and assimilation, and prompt relief of nervous exhaustion, tell why so many physicians look on Gray's Glycerine Tonic Comp. as the ideal hot weather tonic.

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Walter S. Hatfield, Walnut Hill, Cincinnati; Hahnemann Medical College of Philadelphia, 1882; aged 66, died May 25 from carcinoma of the transverse colon.

Fred Augustus Hall, Roslindale, Mass.; Boston University, 1899, aged 52; died May 12.

Geo. W. Higbee, M.D., of Sullivan, Indiana; a graduate of the Homœopathic Medical College of Missouri, 1870; a veteran of the Civil War; died June 12, at the age of 78 years.

Ernest C. Brown, M.D., of Madrid, Iowa; a graduate of the Homœopathic Department of the University of Michigan, of 1893; died May 30, of tuberculosis at the age of 53 years.

Grant Newton, M.D., of Dexter, Missouri; a graduate of the Chicago Homœopathic College, 1894; died June 14th with dropsy, at the age of 52 years.

Samuel Clymer Moyer, Lansdale, Pa.; a graduate of the Hahnemann Medical College, Philadelphia, 1872; aged 73 years. Dr. Moyer's death was the result of a grade-crossing accident a few miles from his home. He was an active member of the American Institute of Homœopathy and of the Homœopathic Medical Society of the State of Pennsylvania.

Harvey Gilbert, M.D., a graduate of the New York Homœopathic Medical College, 1874, at one time coroner of Bay County, and health officer of Bay City, died at his home May 2, aged 73 years, from cerebral hemorrhage.

Chas. F. Cushing, M.D., of Elyria, Ohio; a graduate of the Western Homœopathic College, Cleveland, Ohio, 1861; aged 90 years; died May 3, from cerebral hemorrhage.

Thos. G. McPherson, M.D., of Beaver Falls, Pa.; a graduate of the Western Homœopathic College, Cleveland, Ohio, 1864; aged 82 years; died May 9th.

Mary Miller, M.D., Philadelphia; graduate of the New York Medical College and Hospital for Women, 1878; aged 82 years, died in the Home for Indigent Widows and Single Women, Philadelphia, May 11, from cerebral hemorrhage.

Corresta D. Canfield, M.D., Pittsburgh, Kansas; a graduate of the Homœopathic Hospital College, Cleveland, 1872; aged 87 years; died at the home of her daughter, in Pittsburg, May, following an attack of influenza.

Edward Cranch, M.D., of Erie, Pa., for many years an active member of the Homœopathic Medical Society of Pennsylvania; a graduate of the Georgetown University, Washington, D.C., 1873, and of the N. Y. Homœopathic Medical College, of 1875; aged 68 years; president of the Erie County Society in 1919; consulting physician to Hamot Hospital, Erie; died May 20th of aneurysm of the aorta.

Wm. C. Bell, M.D., Detroit; Detroit Homœopathic College, 1911; aged 33 years; a member of the Michigan State Medical Society; assistant surgeon to the police department of Detroit since 1917; died May 19th, from pneumonia.

Malcolm G. Violet, of Waterford, Wisconsin; a graduate of the Chicago Hahnemann Medical College, 1886; died February 27th.

William Olin Forbes, Hot Springs, Arkansas; Hahnemann Medical College, Chicago, 1896; aged 50; a member of the Arkansas Medical Society; formerly president of the Federal Medical Board of the Hot Springs Reservation, and a member of the Illinois State Board of Health; died in Lincoln, Nebraska, August 26.



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Charles Holt Thomas, Cambridge, Mass.; Boston University School of Medicine, 1888; aged 70; a member of the Massachusetts Medical Society; professor of clinical medicine in his alma mater; visiting physician to the Massachusetts Homœopathic Hospital; died, September 4, from heart disease.

Harry Deacon Wilson, Freeport, Ill.; Hahnemann Medical College, Philadelphia, 1897; aged 59; a member of the Illinois State Medical Society; while making a professional call, August 23, died suddenly from heart disease.

John P. Bahrenburg, Nashville, Ill.; Homœopathic Medical College of Missouri, 1879; aged 89; died at the home of his daughter in Marissa, Ill., August 18, from senile debility.

Daniel Yoder, Catasauqua, Pa.; Pennsylvania Medical College, Philadelphia, 1858; aged 86; died August 24. For many years Doctor Yoder was very active in his interest in the Homœopathic Medical Society of Philadelphia, and was well known to all of the older members. Owing to the infirmities of age, he has not been with us for a number of years past. He still retained however, an active interest in his professional work in the Lehigh Valley where he was worshipped by his brother practitioners and looked up to as their dean.

Charles W. Radway, Mexico, N. Y.; New York Homœopathic Medical College, New York, 1876; a member of the Medical Society of the State of New York; died August 2.

Karl J. Severance, Keeseville, N. Y.; Hahnemann Medical College, Chicago, 1889; aged 54; died July 28, from meningitis.

Edward W. Crecilius, Norwalk, Ohio; Cleveland Homœopathic Medical College, 1900; aged 48; died July 10, from tetanus.

Mary E. Smith, Elk Run, Pa.; Homœopathic Hospital College, Cleveland, Ohio, 1887; aged 72; died July 30.

Walter Wesselhoeft, Cambridge, Mass.; Harvard University Medical School, 1859; aged 82; professor of clinical medicine in Boston University Medical School until 1909 and since that time emeritus professor; consulting physician to, and a member of the board of trustees of, the Massachusetts Homœopathic Hospital; died at his summer home at Sandwich, Mass., August 17.

Wilbur Daniel Cook, Chicago; Hahnemann Medical College, Chicago, 1900; College of Physicians and Surgeons, Chicago, 1909; aged 57; a member of the Illinois State Medical Society; for many years attending physician to the John Worthy School; a specialist in diseases of the eye, ear, nose and throat; died, August 23, from cerebral hemorrhage.

Henry W. Roby, Topeka, Kan.; Hahnemann Medical College, Chicago, 1877; aged 78; a member of the staff of Christ's Hospital; a veteran of the Civil War and afterward a court reporter in Kenosha and Milwaukee, Wis.; died, August 22.

Jacob Wilbert Light, Kingman, Kan.; Pulte Medical College, Cincinnati, 1884; aged 60; a member of the Kingman County Medical Society; died in Santa Monica, California, August 12, from heart disease.

Milton Cooper Egbert, Pittsburgh; Western Homœopathic College, Cleveland, 1860; aged 82; died May 21, from senile debility.

George Henry McLin, Huntingdon, Ind.; Hahnemann Medical College, Philadelphia, 1871; aged 77; died August 17.

Leonard S. Ordway, Denver; Homœopathic Medical College of the State of New York, New York City, 1864; aged 78; died in Ticonderoga, N. Y., August 17.

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Solace, May 26th, 1920, while at the Southern drill grounds (big gun practice) and was assigned to the U. S. Naval Hospital, League Island, Philadelphia, pending his release from the service.

Dr. Ella D. Goff, Treasurer of the Homœopathic Medical Society of Pennsylvania, has recovered from her severe illness sufficiently to return to her home. The many members in attendance upon the recent session of the Society missed her presence. Her brother-in-law, Mr. Sion B. Smith acted as her substitute at the treasurer's desk. Efficient as he was, he did not make up for Dr. Goff. In its 57 years of existence, the Pennsylvania Society has had but two treasurers, Dr. Jno. F. Copper and Dr. Ella D. Goff. It was fitting therefore that Dr. Goff should be unanimously elected as usual. The Society furthermore testified its appreciation of her services by telegraphing to her its best wishes, and accompanying the telegram by a message to a Pittsburg florist to send her a suitable floral offering.

Dr. M. F. Pettler has completed his service at the Pittsburgh Homœopathic Hospital and has located at 14th and Merchant Street, Ambridge, Pennsylvania.

Doctor William Alvah Stewart has been transferred from the Gynecological to the Surgical Service of the Pittsburgh Homœopathic Hospital.

Mr. and Mrs. John Conly Banner announce the marriage of their daughter, Sarah Kathryn to Doctor William Satterer on Saturday Oct. 2, 1920, at Newark, New Jersey.

Mr. and Mrs. Henry Harrop announce the marriage of their daughter, Louisa Alberta to Dr. Earl Crosby Lyon, on Saturday, October 2, 1920, at Phoenixville, Pennsylvania.



William de Forrest Voorhees, Auburn, N. Y.; New York Homœopathic Medical College, 1915; aged 27; died, August 28.

William Pinkney Roberts, Los Angeles; Hahnemann Medical College, Chicago, 1876; aged 84; died June 5.

### PERSONAL.

Doctor and Mrs. David Campbell Kline announce the marriage of their daughter Rada to Mr. Robert Herndon Maxwell on Tuesday, the twenty-first of September, nineteen hundred and twenty, Reading, Pa.

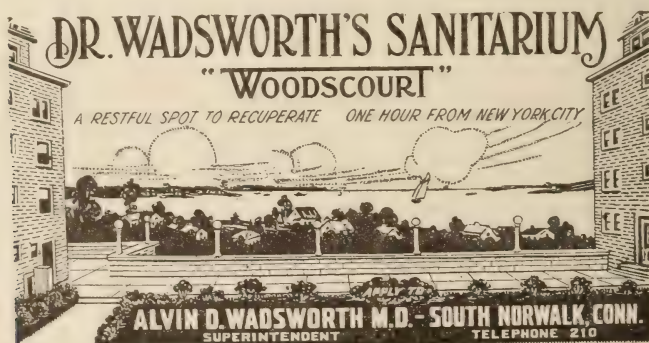
Dr. B. Bertram Fenimore, announces the removal of his office from 2 North 50th Street to 135 North 50th Street, Philadelphia, Pa. Office hours: until 10.00 A. M., 6.30 to 8.00 P. M., except Tuesday evenings and Sundays.

Dr. Wallace E. Prugh has finished his term of service as interne at the Pittsburgh Homœopathic Hospital, and has located at 1102 North Main Street, Dayton, Ohio.

Dr. William Rendell Williams announces that after October 1, 1920, his office hours will be from 9 A. M. to 12 M. Sundays and other hours by appointment. 2010 Chestnut Street, Philadelphia. Telephone Spruce, 2400.

Dr. Percy H. Ealer, announces the removal of his offices to the Professional Building, 1831 Chestnut St., October 1st, 1920. Hours: 10:30 to 12. Evening hours: 7 to 8 P. M.; 2027 Spring Garden Street.

Dr. Francis L. Hughes having completed his service in the U. S. Navy announces the opening of his office, 721 Weightman Building, 1524 Chestnut Street, Philadelphia. His practice will be limited to Gynaecology and Abdominal Surgery. Office hours are 2 to 4 P. M. daily (except Sunday). 6 to 8 P. M. Tuesday, Thursday and Saturday. Phone Spruce, 1116. Doctor Hughes entered the Naval Service July, 1918, and was assigned to the 4th Naval District as assistant to the Medical Aid; in July, 1919, was ordered to join the U. S. S. Solace (Hospital Ship) at Portsmouth, N. H., as operating surgeon. The Solace being the Hospital Ship attached to the Atlantic Fleet, Dr. Hughes accompanied the Fleet during the winter and spring manœuvres, visiting Cuba, Porto Rico, Virgin Islands, Canal Zone and Jamaica. During the entire cruise he was responsible for all the operating for the Fleet, doing eighty-five (85) major operations in fifty-three (53) days, not including fractures and minor operations and injuries. Dr. Hughes was detached from the



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

NOVEMBER, 1920

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**Physiology and Biochemistry in Modern Medicine**, by J. J. R. MacLeod, M.B., Professor of Physiology in the University of Toronto, Toronto, Canada; formerly Professor of Physiology in the Western Reserve University, Cleveland, Ohio, assisted by Roy G. Pearce, A. C. Redfield and N. B. Taylor and by others. Third Edition. With 243 illustrations, including 9 plates in colors. St. Louis, C. V. Mosby Co., 1920.

In the application of new knowledge of medicine to the treatment of the sick morbid anatomy is becoming subordinated to the study of disturbed function and of physiological chemistry. For many years MacLeod has been identified strongly with the advances in this latter science and the previous editions of his work have stamped him as a great authority.

Many changes have been made in the present (third) edition of the book. The section on the nervous system has been entirely recast and rewritten by A. C. Redfield, who, besides bringing this part of the subject up to date, has incorporated with it an account of the fundamental principles of neuromuscular physiology. Although no application of this subject may at present be apparent in the investigation of disease, it is certain that such exists; but it can be made only after the clinical researcher has become familiar with the brilliant work which has been done in the field in recent years by Keith Lucas, Adrian, and others. It is the function of a volume of this nature to describe not merely what already has been achieved in the clinical applications of physiology, but also to anticipate where this application is likely soon to be made and to prepare the way by describing the physiological principles that may be involved.

Another section in which complete changes have been called for, is

that relating to the chemistry of respiration. This has been rewritten and rearranged so as to incorporate the recent work on the effects of deficiency of oxygen on the respiratory center, as well as the interesting and important clinical applications of the subject. Several new chapters have been added dealing with such practical problems as the measurement of the functional capacity of the heart, the principles of ventilation and the therapeutic value of oxygen, and the chapters on vitamins, on the capillary circulation, on surgical shock, and on the interpretation of polysphygmograms have been rewritten.

In practically every other section of the book many additions have been made, particularly in that which deals with the endocrine organs and several new figures and tables have been added.

The book is likely to be more popular with the younger generation fresh from college and with the medical student still laden with the fundamental principles of modern medicine. Probably the man in practice twenty-five years or more can hardly grasp the subject unless he has acquired the fundamental details.

**Homœopathic Medical Society of the County of New York.**—The regular meeting of the Homœopathic Medical Society of the County of New York was held at the Academy of Medicine, 17 West 43rd St., Oct. 14, 1920. In the absence of the President and Vice-President the meeting was called to order at 8:15 P. M. by the Necrologist, Philip Cook Thomas, M.D. Attendance 34. The minutes of the last meeting were read and approved.

Letter from Dr. J. B. Garrison with reference to the reinstatement of Dr. Ferdinand Seeger, 400 East 93rd St., was read by the Secretary, and on motion it was voted that his name be printed on notices for reinstatement at the November meeting. The Secretary presented the resignation of Dr. W. D. Howland (Corresponding Member) and on motion it was voted to accept same.

The Bureau of Materia Medica and Therapeutics, J. P. Seward, M.D., Chairman, presented a thoughtful and discriminating paper entitled "The Clinical Aspects of Arsenicum Album" by G. B. Stearns, M.D.

Discussion—R. F. Rabe, M.D.: Its great adaptability is in septic infections and low states of vitality. It is rather more frequently indicated in chronic than in acute conditions. Arsenic and phosphorus are complementary. Clinically they are related. Another very useful remedy in septic conditions is pyrogen, which follows well sometimes after arsenicum. The key-note for Pyrogen is the disproportion between pulse and temperature, usually high pulse rate and low temperature.

General Discussion—G. W. Roberts, M.D., F.A.C.S.: Did I understand Dr. Stearns to state that the case of septic pericarditis had been cured by Arsenicum, as I have never seen a case recover. Dr. Stearns replied in the affirmative.

B. G. Clark, M.D.: Secale has same prostration as arsenic, but arsenicum patient desires warmth whereas secale patient craves cold and wants bed clothes thrown off.

P. C. Thomas, M.D.: Was any bacteriological examination made in case of septic pericarditis? To which Dr. Stearns replied, there was.

G. B. Stearns in closing discussion, said: Secale cases are warm all of the time, but crave the cold air.

R. F. Rabe, M.D. presented a paper entitled "Psorinum," and spoke



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in his usual earnest and convincing manner. Among other remarks, he said, one of the characteristic symptoms of psorinum is extreme sensitiveness to cold, they (the patients) always bundle up well, whereas pulsatilla, lycopodium and sulphur patients crave cold air. It is of great benefit in catarrhal conditions, characterized by the extreme offensiveness of the discharges. Another remedy somewhat similar to it is kali muriaticum. Repeated attacks of suppurative tonsillitis with the characteristic offensive discharge have yielded to this remedy where others apparently indicated have failed. It is a valuable remedy in diseases of the skin, particularly of eczematous character, with itching, profuse offensive discharge, aggravation from the warmth of the bed; this symptom is only true of the skin eruptions where this remedy is indicated.

All cases where psorinum is the proper remedy are worse in the winter.

Very useful in diarrhoea where the stools are dark and very offensive, also in constipation, with difficulty in expelling even a soft stool.

Hunger at night is a leading characteristic; chronic otorrhoea with exceeding offensive discharge. It is very useful in hay fever with asthmatic breathing, relieved by lying down, must have a warm atmosphere. Mentally depressed, discouraged, little effort causes them to perspire freely. Night sweats.

Discussion—B. G. Clark, M.D.: I have found psorinum useful in skin symptoms from suppressed eruptions, and in diarrhoeas with extremely offensive odor of stools. Patients awake in the night hungry. One case of hay fever was markedly relieved by psorinum. It is useful sometimes as an intercurrent remedy, where one apparently indicated has failed to produce results. I always use the remedy in the 200th.

Edward Rushmore, M.D.: I concur most cordially with the Essayist and with what Dr. Clark has said in the discussion. The symptoms I have found of service under psorinum are sadness, despair, melancholy, suicidal tendency, itching of the skin. Eruptions are moist and offensive, moist scabs on or about the ears, offensive discharge from the ears, craving for food not only at night but anytime, very offensive diarrhoeas. In chronic diseases psorinum is the remedy to use as an intercurrent, whereas in acute diseases sulphur is the remedy.

Dr. Rabe in closing discussion, gave a most cordial invitation to all to be present at Flower Hospital on "National Clinic Day," Oct. 19th, 1920, and Dr. Hetrick for the Ophthalmic Hospital gave a similar invitation for the same date.

The Bureau of Obstetrics, P. C. Thomas, M.D., Chairman, presented a very concise and practical paper entitled "Management of the 2nd Stage of Labor," by S. J. Scadron, M.D.

Discussion—L. S. Loizeaux, M.D., F.A.C.S.: Episiotomy is a boon often to end the 2nd stage of labor, I have done it in 75 per cent. of the cases in primipara in the past year. It is so easy of accomplishment and often shortens the 2nd stage of labor by at least one-half hour. It is a great adjunct to low forceps cases. Both the lateral and posterior operations are showing good results. Must have good anesthesia, and we should wait before performing the operation until the head is well down on the perineum, unless strain is too great on the perineum. It has come to stay in the hands of careful operators.

H. B. Safford, M.D., F.A.C.S.: It is an excellent operation in selected cases. Would not think of using it in all primiparas. I have always

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used the lateral method. Dr. Scadron in closing discussion said, I do not perform episiotomy as a regular thing.

The Bureau of Surgery and Gynecology, M. W. McDuffie, M.D., Chairman, presented a clear, comprehensive and exceedingly practical paper entitled, "The Surgical Treatment of Pelvic Inflammations," by H. B. Safford, M.D., F.A.C.S.

Discussion—G. M. Roberts, M.D., F.A.C.S.: Paper covers a wide field, I would divide Pelvic Inflammations into two classes, Gonococci and Traumatic Puerperal. With reference to the time for operation, sometimes it is advisable to operate in acute attack and in others it is better to wait. Have closed many cases, especially pus cases, without drainage, but sometimes one slips up and you find the case is not in the quiescent stage you imagined.

I would advise the use of small drainage tube in all cases. I believe it is necessary sometimes to use the curette where the fingers cannot be used for the purpose. Essayist has said that inflammatory masses frequently disappear without operation, but in my experience they have rarely disappeared. If diagnosis is in doubt, make exploratory incision, open abdomen, make diagnosis and get proper drainage.

H. E. Ayres, M.D., F.A.C.S.: The paper is a very able one. Puerperal cases are usually septic; surgical treatment is absolutely necessary in all of these cases.

General Discussion—S. J. Scadron, M.D.: I do not use the curette unless I have good reason to believe that placental tissue is in the uterus. We should defer operations, rather than perform them early.

M. W. McDuffie, M.D.: History taking in hospitals is poorly done. Greater care should be taken to obtain a full and complete history. Great care must be exercised in handling of pus in the pelvis. We do not use morphin in post operative cases as much as we should.

L. S. Loizeaux, M.D., F.A.C.S.: In septic abortion cases we must use curette, as you cannot get into the uterus with fingers. I cannot give up the use of the douche. In gonorrheal cases we have done harm by waiting too long to operate.

R. F. Rabe, M.D.: The surgeons in these cases should call to their help eminent materia medicists, not to usurp the cases, but to help in selecting the properly indicated remedy, so that we may have team work.

Dr. Safford in closing discussion said: In puerperal infection of the uterus I can do better work with my fingers than I can with the curette.

On motion of Dr. Rabe, seconded by Dr. Greenwald a unanimous vote of thanks was tendered Dr. Scadron for his interesting paper. Meeting adjourned at 10.25 P. M.

Charles Ver Nooy, M.D., Secretary.

**The Opening of the Lee Hospital at Johnstown** was the means observed for the celebration of National Homœopathic Clinic Day at Johnstown, Pa. This hospital is the result of a bequest of Mrs. Emily M. Lee, the widow of Dr. John K. Lee, who practiced Homœopathic Medicine in that city for many years, and who perished in the Johnstown flood. Mrs. Lee died in March 1916, and left her estate, estimated as worth about \$200,000 to the construction of this hospital. Many of the citizens of Johnstown visited the new hospital and expressed themselves well pleased with its equipment, especially the operating room, the sterilizing room, the men's ward, the receiving ward, the X-ray room, the laboratory and the cozy private rooms. The hospital staff is composed of the fol-

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lowing: Drs. Horace E. Kistler, Harry Sanderson and William Wallace, medical staff, and Drs. Claude J. Wesner, L. A. Wesner and Paul J. Riddles, surgical staff.

**National Clinic Day at Hahnemann Hospital, Philadelphia.**—The clinics at the Hahnemann Hospital, Philadelphia, were all held to full houses. The program, as outlined in our editorial, was followed out to the letter. Arrangements have been perfected by which the entire series of clinics will appear in the January Hahnemannian, and will probably make a volume of clinical reports exceeded in value by none previously published anywhere or by anybody.

**Homœopathic Medical Society of Chester, Delaware and Montgomery Counties.**—A meeting of the Tri-County Medical Society of Chester, Delaware and Montgomery Counties, was held on Tuesday, October 12th, at the West Chester Country Club, West Chester, Pa. Twenty-seven doctors were present, and after enjoying an excellent dinner, the society came to order. After transacting some minor business, turned to the election of officers for the ensuing year. The report of the election of officers was as follows: President, Dr. S. A. Mullin of West Chester, Pa., Vice-President, Dr. Alpheus Gregg of Kennett Square, Secretary, Dr. F. T. Krusen, Norristown, Pa., Treasurer, Dr. A. R. Garner of Norristown, Pa., and Necrologist, Dr. G. C. Webster, Sr., of Chester, Pa. It was then moved and seconded that Dr. R. P. Mercer of Ridley Park, be made an Honorary Member; was also moved and seconded that the resignation of Dr. Wesley Rennie be accepted.

After the business meeting, Dr. Charles Palmer of West Chester, read an interesting paper on Scrotoctomy, which will appear in full in the "Hahnemannian Monthly."

After a short discussion, Dr. Samuel Sappington of Philadelphia, read an excellent paper on "The Marrow Factor in Grave Anaemias."

The speakers were then accorded a rising vote of thanks and the meeting adjourned to meet again at The University Club, the second Tuesday in December.

**Homœopathic Medical Society of Philadelphia County.**—The regular monthly meeting of the Homœopathic Medical Society of the County of Philadelphia was held Thursday evening September 16, 1920 at Hahnemann College. Dr. W. D. Bayley made an interesting report of the meeting held at Willow Grove, September 2, 1920. There were about two hundred physicians present. This meeting will probably be held every year at the same place, the object being to promote Medical unity and good fellowship. Dr. Wm. W. Van Baun was nominated for Honorary Membership. The President in his address spoke of the large attendance at the meetings of the preceding year, and the splendid work of the program committee in securing unusually interesting scientific papers. He made a plea for continued support and interest in the County Society, thereby not only benefiting the attending members but the College as well. Dr. T. H. Carmichael read a paper on Compulsory Health Insurance which set forth very clearly the disadvantages of such a law to the Medical Profession. Dr. E. M. Gramm opened the discussion and showed how such a law would work using a very carefully prepared



## Quotations from Doctors: No. 7

"The majority of cases of pneumonia, in my experience of thirty years' medical practice, have had more or less pleuritic complications.

"I presume this is the experience of my colleagues.

"The most grateful application that can be made to a patient suffering with pneumonia is a warm



poultice under a moderately firm binder or jacket. Its action is, first through the superficial vessels, and then more slowly but just as efficiently on the deeper congested parts."

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chart to show the relationship of the many bureaus. This meeting certainly was of unusual interest to the entire Medical Profession.

Theodore K. Gramm, Secretary.

**Homœopathic Medical Society of the County of Philadelphia.**—The regular monthly meeting of the Homœopathic Medical Society of the County of Philadelphia was held Thursday evening, October 14, 1920 at Hahnemann College. There was a very large attendance at this meeting. After the usual business meeting the evening was devoted to a discussion of Hay Fever. Dr. J. V. F. Clay presented the first paper entitled "The Modern Conception and Causes of Hay Fever." Dr. H. S. Weaver read a paper upon the "Homœopathic Remedies Useful in the Treatment of Hay Fever." Dr. Wm. M. Hillegas spoke on the local Treatment of Hay Fever. Dr. S. W. Sappington read a paper on the use of "Pollen Extracts in the Treatment of Hay Fever." Dr. Wm. G. Shemeley, Jr., demonstrated Autogenous Therapy in Hay Fever Cases.

Theodore K. Gramm, Secretary.

**Connecticut Homœopathic Medical Society**—National Homœopathic Clinical Day was observed at the Norwich State Hospital in a most profitable way. Dr. Chas. Swann Smith, held a clinic on a hernia case, operating a case which had formerly been operated and torn through. Dr. Marshall J. Adams held a clinic operating a large carcinoma of the uterus. The Superintendent, Dr. F. S. Wilcox gave a valuable talk upon the care of the insane with reference to the employment of the insane. Dr. F. S. Wilcox gave an unusually instructive talk on Sterilization of the Insane, while Dr. Chas. Swann Smith demonstrated the actual operation upon a patient. An inspection of the large new receiving-ward was greatly enjoyed by all.

**Pennsylvania Chamber of Commerce; Compulsory Health Insurance Legislation.**—The following resolutions were passed September 27, 1920:

Whereas, The agitation in behalf of the adoption of a State Compulsory Health Insurance Law has led to the appointment of a legislative commission to study the subject and make a report at the coming session of the Legislature, and

Whereas, The Pennsylvania State Chamber of Commerce has made an exhaustive study of the subject, the report of which has been published, which furnishes convincing evidence of the unwisdom of such legislation, therefore be it

Resolved, That the Pennsylvania State Chamber of Commerce, in convention assembled, is of opinion that there is no general demand for the enactment of such legislation, and no useful purpose would be served by it.

**Central Pennsylvania Homœopathic Medical Society.**—The regular meeting of the Central Pennsylvania Homœopathic Medical Society was held at the Keystone Hospital, the private hospital of Dr. G. W. Hartman, in connection with the observance of the "National Homœopathic Clinic Day," October 19th.

The following operations were performed by Dr. Hartman and staff in the usual brilliant manner: Gastrostomy for artificial feeding in carcinoma of cardiac portion of stomach, total extirpation of enlarged



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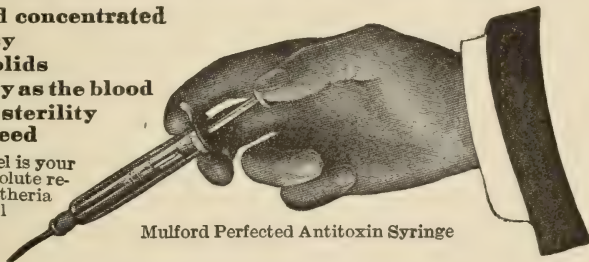
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Following a dinner was a short business session at which Dr. C. R. Miller of Harrisburg, was elected a member and Dr. E. K. Lefever of Carlisle was elected an honorary member. A vote of thanks was extended to all Harrisburg members for the excellent work accomplished in entertaining the State Society in its recent meeting in Harrisburg and to Dr. Hartman for the entertainment of the Society at this time. Auditors found the accounts of the retiring Treasurer correct. The following officers were elected for the ensuing year: President Dr. G. A. Sayres of Lancaster, Vice-President Dr. H. M. Read of York, Secretary and Treasurer Dr. G. C. Schwartz of Lancaster.

Remarks on pertinent subjects were made by Dr. E. T. Prizer: The Application of Homœopathy to Medicine. Dr. G. C. Schwartz: Homœopathy the Science of the Law of Similars of Wide Application. Dr. A. W. Baker; Combinations in Homœopathy.

H. M. Read, M.D., Secretary.

**The West Jersey Homœopathic Medical Society.**—Observed National Homœopathic Clinic Day, Tuesday, October 19, 1920 at the West Jersey Homœopathic Hospital, Mt. Ephraim and Atlantic Avenues, Camden, beginning at 12.30 P. M. Dinner was served at one o'clock. Dr. Chas. F. Hadley, National Committeeman for West Jersey, presided during the Clinic, and had an interesting case for observation. Dr. A. S. Ironside described the Homœopathic treatment in a clinical case.

Dr. W. J. Barrett, President of New Jersey State Homœopathic Medical Society, a clinic. He also made an appeal for help from our members in securing pupil Nurses for the Hospital.

Dr. Douglas Macfarlan, Chairman of Bureau of Surgery, co-operated with the Hospital Staff in clinical cases.

Dr. A. M. Maldeis presented some eye cases.

Dr. Wallace McGeorge gave a phase of Samuel Hahnemann, as the pioneer in treatment of the Insane by kindness instead of brutality.

Frank F. Moore, M.D., Secretary.

Joseph C. Bitler, M.D., President.

**The Clinico-Pathologic Society of Philadelphia.**—The regular meeting of the Clinico-Pathologic Society was held in the Hahnemann Medical College, Thursday evening, October 7th, 1920, at 8.30 o'clock. The following papers were read:

(1) The Effect of Cold Storage upon Food Stuffs, Joseph Hepburn, Ph.D.

(2) The Necessity for Routine Examinations to Avoid Diagnostic Error, Clarence Bartlett, M.D.

Joseph V. F. Clay, M.D., Secretary.

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## DEATHS.

Anna Mary Marshall, Philadelphia; Boston University School of Medicine, 1879; aged 80; died in Lansdowne, Pa., September 20, from pneumonia.

Bernard N. Graeser, Des Moines, Iowa; Hahnemann Medical College and Hospital, Chicago, 1878; aged 83; died September 18.

Harry Burket Fetterhoof, Huntingdon, Pa.; Hahnemann Medical College and Hospital of Philadelphia, 1899; aged 49; a member of the

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Homœopathic Society of the State of Pennsylvania; died at the Blair Memorial Hospital, Huntingdon, September 21, from infected embolism.

Alonzo S. Laskey, Oakland, Cal.; Hahnemann Medical College and Hospital of Philadelphia, 1889; aged 55; died September 27.

Morris J. Moth, Chicago; Hahnemann Medical College and Hospital, Chicago, 1890; aged 67; professor of Materia Medica in his Alma Mater; died October 6.

**Obituary**— Dr. S. C. Moyer of Lansdale, Pa. met with a fatal accident at a grade crossing near Orvilla, Pa. on Aug. 3, 1920. While the doctor's horse was mangled and his wagon literally reduced to small fragments, the doctor's body fortunately escaped being mutilated to any great extent; a broken collar bone and a fractured skull being the only visible evidence of his misfortune. Having been rendered immediately unconscious he lived probably about fifteen minutes till he passed beyond.

Dr. Moyer was seventy-four years old and was graduated from the Hahnemann Medical College of Philadelphia in 1872. He practiced his profession for forty-eight years; forty-six of these have been spent in Lansdale. He was one of the pioneers of Homœopathy in Bucks and Montgomery counties and enjoyed a large practice. He was a staunch Homœopath, was held in high esteem by his clientele and was respected by all who knew him.

He was a member of the Pennsylvania State Homœopathic Medical Society, the Tri-County Homœopathic Medical Society, the North Penn Clinical Society and the North Penn Homœopathic Medical Society, having been the president of the latter since it was organized in January 1908. He was, by faith, a New School Mennonite, being a member of the church at Souderton, Pa.

Dr. Moyer leaves a wife, five daughters and seven sons. He is succeeded in his practice by his son, Dr. Herbert T. Moyer, with whom he had been previously associated, having indeed, largely retired for the past three years.

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### PERSONALS.

Dr. Harold A. Taggart has completed his internship at Hahnemann Hospital and is located at Drexel Hill, Delaware County, Pennsylvania.

Doctors Edwin Lightner Nesbit, and W. Irvine Hamer announce the opening of new offices for the practice of General Medicine in the Rialto Building, Greensburg, Pennsylvania. Dr. Nesbit is giving special attention to children.

Dr. J. W. Goodsell formerly of New Kensington, Pa., has removed to Springdale, Pennsylvania. The Doctor served during the recent war at Camp Oglethorpe and was with the American Expeditionary Force in France. Dr. Goodsell is widely known by reason of his Medical Executive service with Peary in the dash for the North Pole. Following his return from his Arctic expedition the Doctor delivered numerous lectures before geographical and other societies in a number of our large cities. Dr. Goodsell is a graduate of one of our Ohio Colleges.

Dr. Newlin F. Paxson announces that he has associated himself with



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Dr. John A. Holland has completed his service as intern at the Massachusetts Homœopathic Hospital, and is located at South Ashburnham, Mass. He has already been appointed School Physician for the district.

Dr. James W. Fox, announces his removal to Hillsdale, N. J., and the transfer of his practice to Dr. George H. Ding, 364—75th Street, Brooklyn, N. Y.

Dr. Gouverneur H. Boyer, son of Dr. Francis W. Boyer of Pottsville, has received a Major's commission in the regular Army. Dr. Boyer, Jr. enlisted in the Reserve Corps in May 1917. In August he went across and served in the British Army till August 1918, when he was transferred to the 308th U. S. Engineers. He was decorated with the British Military Cross for five days and nights in an advanced dressing station in Belgium in April 1918. He went with the 308th Engineers through the Argonne conflict and spent several months in Germany. In July 1919 he returned to the United States and was assigned to Fort Bliss, Texas, where he still is, and where he is in charge of the Eye Hospital, with plenty of work to do.

**Homœopathic Medical Society of the County of Kings, Brooklyn, N. Y.**—The 530th regular meeting of the Society was held at the Medical Library, September 28, with more than average attendance. Dr. Justus G. Wright, the President, was in the chair. Four names were added to the membership list by election, Dr. Jacob Skeer, N. Y. Hom., '18; Dr. Chester W. Bunnell, N. Y. Hom., '18, who has just finished his internship at the Carson G. Peck Memorial Hospital, and will settle in Brooklyn; Dr. Louis Icahn, N. Y. Hom., '16, and Dr. John Bowie, N. Y. Hom., '16.

The interesting announcement was made that Dr. Otto H. Rohde and his wife, have donated to the school of homœopathy a plot of ground at Freeport Heights, Long Island. The plot consists of 20 lots, is high ground, and suitable for hospital or sanitarium purposes. The gift is made to the Kings' County Homœopathic Society unconditionally, to use as the Society deems wise for the benefit of Homœopathy, the donors asking that it be utilized for the benefit of humanity. Dr. Rohde is a graduate of the New York Eclectic Medical College and has practised in Brooklyn for more than 25 years. He has moved to California permanently, taking up work at Los Angeles, and before he made the change he and his wife desired to leave some memorial of their residence in Brooklyn. Dr. Rohde was a member of the Kings County Homœopathic Society for many years. An offer of two thousand dollars has been made for the ground but the Society has made no plans as to its future use. Should it be sold the fund will be put at interest and the income devoted to the encouragement of homœopathic advancement. The name of Dr. Rohde will be a part of the title of the fund in whatever way it is utilized.

Dr. Royal A. Abbott, read an excellent paper on "Indications for Removal of the Tonsils. A plea for conservatism." He said that frequently cases came into the hospital for operation after the acute stage



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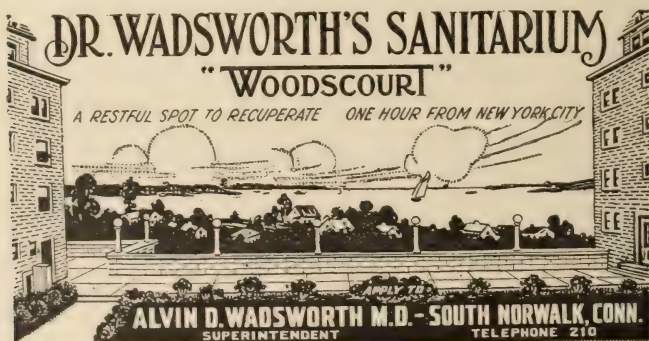
of a tonsilitis and the operator found what appeared to be normal tonsils and the question was whether an operator was justified in operating in such a condition to remove apparently good tonsils. Dr. Abbott quoted one writer who believed that the normal function of the tonsil ceased after eight years of age. In discussing the paper, Dr. R. C. Eckardt said that when the tonsils in cases cited by Dr. Abbott were removed it was remarkable how many showed pockets of caseous matter in the crypts, foci for development of bacteria.

Dr. Edward Chapin read a philosophical paper on "Some Reasons Why Certain Basic Principles Should Be Considered in the Treatment of Disease." This paper was a plea for the proper use of the newer discoveries in medicine as adjuncts to homœopathy, speaking of the various currents of electricity, catalysis, and radium.

By invitation, Dr. Robert Franklin Ives, of Brooklyn read a very excellent paper on "Functional Blood Pressure." Dr. Ives gave the outlines of the recent use of blood pressure and spoke particularly of the necessity for frequent readings of the blood pressure of each patient under varying conditions so that a definite level might be reached, the variations in different parts of the day, when at rest or after exercise, after and before eating all having effect to make differences in pressure. The necessity for taking the diastolic as well as the systolic pressures so that the pulse pressure might be obtained he also emphasized.

A letter was read from Dr. John Newton Goode, of Saranac Lake, N. Y., the tuberculosis colony of the Adirondack region. He said: "More or less all patronage to physicians at Saranac Lake, N. Y., depends on referred T. B. cases from other cities, therefore I fail to understand how the twenty allopaths at Saranac Lake are doing a lucrative business while the two homœopaths have to wait for an occasional happening. I agree that the proportion is twenty to two but I hardly think there are more than twenty men of the old school in the states to every two of the homœopathic school. Outside of a few patients I am able to accommodate at my place the rest are placed in the neighboring cottages, farms, etc. Homœopathy cannot boast of a sanatorium at Saranac Lake and I hope that the homœopathists will wake up and hold clinics in their present locations for the treatment of tuberculosis and when advisable referring such cases to Saranac Lake for homœopathic treatment and homœopathy will be making another great stride towards prominence."

L. D. Broughton, Secretary.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

DECEMBER, 1920

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**Refraction and Motility of the Eye**, with chapters on color blindness and the field of vision, designed for students and practitioners, by Ellice M. Alger, M.D., F.A.C.S. Professor of Ophthalmology at the New York Post-graduate Medical School, etc., with one hundred and twenty-five illustrations, second revised edition. Phila., F. A. Davis Company, publishers, English Depot, Stanley Phillips, London, 1920. Price \$2.50 net.

This little book has been reprinted a number of times without change since its first appearance, but the recent remarkable recrudescence of interest in ophthalmology has made another edition desirable, with some changes and additions.

Prepared originally as a series of lectures to the writer's post-graduate students it included a number of topics not usually found in books on refraction. Every effort was made to avoid the theoretical without sacrificing the essential; to have each subject prepare for and lead up to the following one; to avoid the laying down of dogmatic rules, but to explain reasons so that the student should eventually rely on himself and be prepared to undertake the entire functional examination of the eye.

The common belief that Refraction is nearer an exact science than any other department of medicine has been a great misfortune to Ophthalmology. On this postulate men with equal training should arrive at exactly the same results. It leads many ophthalmologists to consider refraction as professional drudgery, as uninteresting as the measurement of the schematic eye, except for the fee involved; and is the chief basis for the lay belief that it is not essentially a department of medicine at all.

Refraction is more than a science, and the pre-eminent scientist may notoriously be a very poor artist.

Theoretically there are few eyes that could not be "glassed." But if the physician believes that glasses are a nuisance which, like drugs, should only be prescribed when clearly indicated; if he considers not the eyes alone but the whole patient and finally prescribes what he thinks that patient needs, whether it be simply ocular hygiene, or glasses, or an operation; if he then instead of washing his hands of the result like a mere scientist, watches it sympathetically and hopefully, he converts what might be drudgery into service and earns some of the proverbial joy of the artist.

**Short Talks on Personal and Community Health.** By Louis Lehrfeld, A.M., M.D. Agent for the Prevention of Disease, Department of Public Health, Phila., with introduction by Wilmer Krusen, M.D., LL.D., Director (1916-1919) Department of Public Health and Charities, Phila. F. A. Davis Co., Publishers, Phila., 1920. Price \$2.00 net.

This book has been prepared primarily to accomplish the education of the children of today, the citizens of tomorrow. It was designed to instruct the school pupil, the college student and the social worker in the elements of public health. The health talks are arranged in a short concise manner, in popular form, free from technical terms, so as to be readily understood by the average person of school intelligence.

Large industrial plants, appreciating the value of keeping their employes in good health, are adopting facilities such as rest rooms, recreation fields and auditoriums for their benefit. The need for health education among these employes is becoming more apparent each day. The subject matter in this book is so arranged and selected as to fit the need of such education. It is not aimed to teach the public how to treat disease, but rather how to prevent it and avoid it.

Dr. Krusen makes the following remarks in the introduction:

"The health talks in this book have received the hearty endorsement of the Department of Public Health and Charities of Philadelphia. They are written in such popular form as to be understood by every school pupil and college student. The subjects are so varied as to cover a very wide scope of public health work. A more intimate knowledge of these various principles of preventive medicine will be of greater material benefit than all legislation intended to regulate the habits and customs of the very busy American public."

**The Fundamentals of Human Anatomy**, including its borderland districts; from the viewpoint of a practitioner. By Marsh Pitzman, A.B., M.D., Professor of Anatomy in the Dental Department of Washington University, St. Louis. With one hundred and one illustrations. St. Louis, C. V. Mosby Company, 1920. Price \$4.00.

This book was written on a progressive system; that is, the essential facts are first emphasized and then later on details and sidelights gradually added. Every term is explained at its first appearance so that any student without previous special education should be able to follow the text, always provided the preceding parts have been understood and retained. As the title suggests, the rather old-fashioned pedagogical rule of "teaching more by not attempting to teach too much" has received attention. A conscious attempt has been made to pay more regard than has been customary to the modern pedagogical emphasis on the correlation of



*"In all infectious diseases, in all chronic anæmic and asthenic conditions, the mineral content of the Organism becomes impaired."*

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ideas. Logic has been introduced as far as possible to take the place of memorizing, of which there is at best in anatomy necessarily a great amount. The advantage of this method is that in practice a fact held by understanding is retained much longer and more effectively than one entrusted to memory. For the most part, the text has followed the Basle revision of anatomical nomenclature. As this book makes no pretense except as an auxiliary to more complete works, only such diagrammatic illustrations have been used as seemed indispensable to the author.

**The Essentials of Histology.**—Descriptive and Practical. For the use of students, by Sir Edward Sharpey Schafer, F.R.S., Professor of Physiology in the University of Edinburgh, Formerly Jodrell Professor of Physiology in University College, London. Eleventh Edition. Published by Lea and Febiger, Philadelphia and New York, 1920. Price, \$4.50.

As its title indicates, this is an elementary text book of Histology, presenting the essential facts of the science and omitting less important details. For a complete study of the subject physicians and students may refer to Schafer's text book, on Microscopic Anatomy, and the portions of Quain's Anatomy which deal with the nervous system and the sense organs.

For conveniently accompanying the work of a class of medical students, the book is divided into fifty lessons. Each of these may be supposed to occupy from one to three hours, according to the relative extent to which the preparations are made beforehand by the teacher, or during the lesson by the students. A few of the preparations cannot well be made in a class, but it has been thought inadvisable to injure the completeness of the work by omitting mention of them.

Only those methods are recommended upon which experience has proved that dependence can be placed, but the directions given are for the most part easily capable of modification in accordance with the experience of different teachers.

Few books have attained the high honor of eleven editions.

**Simplified Infant Feeding**, with eighty illustrative cases. By Roger H. Dennett, B.S., M.D., Associate Professor of Diseases of Children, New York Post-Graduate Medical School, Attending Physician of the Children's Department, New York Post-Graduate Hospital, Assistant Attendant Physician at the Willard Parker Hospital and Pediatricist to the New York Lying-in Hospital. Second edition, revised and enlarged, with fourteen illustrations. Published by J. B. Lippincott Company, Philadelphia, 1920.

The first edition of Dr. Dennett's Infant Feeding appeared five years ago and was written to meet the need of something concrete in the form of a book "that will tell the busy practitioner just how to feed the different babies with whom he comes in contact day after day." The author produced a work which was eminently practical and conspicuously lacking in a discussion of the various theories of infant feeding which only serves to confuse and discourage the general practitioner rather than aid him in his pediatric practice.

How well the author succeeded in his presentation of the subject of infant feeding is well attested by the popular reception which his book received at the hands of the medical profession. In re-writing the book

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for the second edition, the author has been gratified, and he may well pride himself on this point, to find that the method described in the first edition has stood the test of time. New and helpful additions to our knowledge of infant feeding have, however, been made during the past five years and the second edition has accordingly been brought up to date by including such subjects as Acidosis, Salts of Milk and the Hypertonic Infant. The author has called upon Dr. M. C. Pease to prepare the chapter on Acidosis and Drs. H. I. Bowditch and A. W. Bosworth for the chapter on Salts of Milk.

Dr. Dennett advocates the use of whole milk diluted with plain water and boiled if necessary to overcome any digestive disturbances. He bases the calculation of the amount of milk and carbohydrate required entirely on the caloric needs of the infant. His exposition of the subject is clear and concise and the directions given for estimating a feeding formula and for preparing the food are practical. The title, "Simplified Infant Feeding," properly designates the scope of this book. Dr. Dennett's book has perhaps done more good in establishing a safe and sane basis for every-day infant feeding than any other work on this subject and it should be in the library of every physician who practices pediatrics.

**Annual Meeting of the Southern Association at Richmond.**—The last day, which with its peculiar circumstances, haunts all convention presidents, was at the Richmond meeting of the Southern Homœopathic Medical Association, one of the best. The several bureau programs of that day were excellent, of course, but more than that, the attendance was good, while the interest and enthusiasm continued strong and forceful, down to the last hour.

The entire three days were full of interest and a variety of happenings that permitted not a dull hour. President Smethers made a prompt start with the first business session, so that the bureau work would suffer no delay, for the full programs and large number of participants present required close attention to avoid overlapping. Committees in charge of special features of Association work and several important American Institute committees required all of the three days and nights to complete their work, so while the bureaus proceeded with scientific matters, much of the no less important business affairs of the two organizations was being accomplished.

For the Southern, federation with the Institute was completed, a permanent committee for securing students from the south and for general propaganda was established, and various plans for stronger organization of the Southern were consummated. The Institute trustees elected an editor for the Journal, a promising plan to secure adequate funds for financing the great work of this organization was put on the ways, and many matters vitally pertaining to the activities of homœopathic colleges, hospitals and other institutions were proposed, considered or entirely consummated. In this first meeting at which he presided, President McCann showed a grasp of the duties in his charge and set a pace in handling them, that merit the devoted co-operation of his associates and must soon produce the results that he plead for.

In the several bureaus, the high-grade work of essayists and discussants was well up to the superior standard of those in our school who speak and write. Throughout the long list of papers ran a thread that showed plainly the strong desire of these men and women to carefully

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guard the physical welfare of the people, a desire above all else to prevent disease, that proudest and most sacred object of our profession, and to give to those who are sick, the fullest limit of measures for diagnosis and treatment intended to restore their health. Many of the discussions were spontaneous, without previous preparation, and the broad, progressive, efficient standards of the homœopathic school were well represented by those thoroughly informed discussants who in their conclusions showed an intimate knowledge concerning the best thought and work in the world of their profession.

The Bureau of Materia Medica, Dr. F. L. Juett, Lexington, Ky., contained a list of speakers that in itself was full guarantee for an excellent program. This list included Drs. W. A. Dewey, Ann Arbor, and Dr. M. E. Chandler, Flint, Mich.; R. A. Rabe, New York; Clarence Bartlett, Philadelphia; H. B. Baker, Richmond, and C. A. Schulze, Columbus, Ohio. The chairman of the bureau, Dr. Juett, offered this program as another instance of the capable work that he has long been doing for the Southern Association, and which service was rewarded and the Association honored by his election at this annual meeting to the chief office in the Southern.

At 2 P. M. on Wednesday, Dr. Wm. H. Gillette, Captain, United States Public Health Service, made an address on the subject of venereal diseases and told of the work being done by the Public Health Service in preventing the spread of these diseases. Dr. Gillette is an experienced worker in this service and is very much alive to the importance of venereal diseases as affecting the health of our people. His talk was instructive, and assured our doctors that their individual efforts in prevent-

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ing these diseases, meets the full endorsement and will receive hearty co-operation by the national department of health.

On this same day the "big" committees convened in a joint conference. Dr. Gilbert Fitzpatrick, Chicago, spoke on Organization and College Affiliations; Dr. Claude Burrett, Columbus, Ohio, on New Things Now Appearing in the Homœopathic Field of Education; Dr. Roy Upham, Brooklyn, N. Y., on Status of Homœopathic Affairs as Demonstrated by Clinic Day; Dr. Martin Z. Westervelt, New Haven, Conn., on The Stand the Institute Should Take in Maintaining Hospitals and Colleges Which Have Been Provided by Homœopathic Money for the Advancement of Homœopathy; and Dr. Guy M. Cushing, Chicago, on State Boards and Hospital Standardization. These speakers, as representatives of the American Institute, and of the Homœopathic School, made the fact impressively conclusive, that the desire throughout is for the highest standard of requirements, in all matters pertaining to medical education and in their service to the public.

At the public meeting on Wednesday night, Dr. J. P. Sutherland, Boston, told of the work that Homœopathy is doing and in his address he presented this school as the only one which rightfully claimed to cure the sick, in elucidation of which statement he pronounced the Galenical principle of *contraria contrariis* as the antipathic or palliative principle, while heteropathy, or allopathy, he described as "essentially empirical in its nature and frequently has an assumed etiological factor or a pathological theory as its point of attack, its search for 'specifics' having proved a disastrous failure." Dr. Sutherland and Dr. Roy Upham have recently returned from Europe, where they attended at The Hague the meeting of the International Homœopathic Council, both having represented the American Institute, while Dr. Sutherland served as President of the Council. At this public meeting of the Association, not so many laymen were present as was desired, in view of the character of the program. Dr. Sutherland's address told much concerning principles of the school, regarding which the public evince a sincere desire to know. Dr. W. A. Dewey showed lantern slides of homœopathic hospitals and other homœopathic institutions of the world. This matter, also, is of interest to laymen and gives them some idea of the material assets of homœopathy. The various features of the annual meeting were so uniformly successful that we feel privileged to frankly state that the audience at the public meeting was in size not up to expectations, and as sincerely to ask for suggestions, in view of other public meetings to be held, whereby a full audience of laymen may be secured.

On Thursday, the Bureau of Ophthalmology, Otology and Laryngology held its meeting. This interesting and forceful unit would have been a distinct attraction at any medical gathering, and so it proved for the Southern Association. Our Association, moreover, holds a strong feeling of appreciation for this "O. O. and L." Society, and those of us who have had something to do with producing the annual meetings of recent years, can testify that it never fails us. Led by Burton Haseltine, Dr. Palen, Dr. George MacKenzie, and other able men before them, they have come to the Southern annuals, no matter where they were held, and with the splendid material always available in their ranks, they presented each time a program that in itself was well worth the journey to hear, and which brought their important specialty into closer and more bene-

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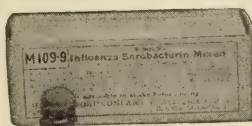


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ficial relation with the other professional branches. Once more the Southern thanks you, O., O. and L., for your co-operation at the Richmond meeting.

On Thursday, a large delegation came to Richmond from Ohio. This party was led by Dr. Thomas McCann, though not by him "personally conducted." Expert guidance of the kind is not necessary to those Ohio doctors, for long ago they learned their way to Southern Association meetings and to know their way around when they got there. Many of the Ohio delegation were posted for papers or discussions in the various bureaus, or for other duties in connection with the meeting. Dean Burrett was there, with his inspiring enthusiasm and with his generous willingness to aid every deserving project for the homœopathic school. Around him are developing others of the same kind, and little wonder that at about every meeting we hear of big things being done at the Columbus college, or that as with the nation's affairs, Ohio is writ largely on the map of Homœopathy.

At the dinner on Thursday evening, relaxation was the order, but here, too, matters Homœopathic were discussed, for the opportunity was favorable since all present were in full sympathy with plans to advance the school. President McCann must have fairly lived the subject of finance since his election last June, for at nine a. m. on Thursday he was going strong in the trustees' board on this subject, and still at eleven that night, he was talking this same topic to diners at the Westmoreland Club. And he merits the support that he pleads for, the aid in raising money in amounts that will let the Institute do the great work that it is so able otherwise to do. It is easy to sense the greater strength and power that has come to the Homœopathic School, and President McCann begs only that we be wise enough to take advantage of these unprecedented opportunities, which can be accomplished only if we, its members, quickly produce the funds which in amount we would consider small enough and easily produced for almost any other project in which we might be engaged.

At the trustees' meeting, these plans were accorded full endorsement. A few hundred dollars from each of us, paid in convenient time, will make an amount that, as an endowment or if spent outright, would raise our school to a plane of accomplishment that must redound to the personal benefit of every homœopathic doctor in the land, along with the great benefit to people that this less fettered more free handed state financially will assure. In this day of making and giving money, yea, in that day when he had less to give, no worthy project went empty handed from the doctor's door. Now, comes a need for funds to advance the work of his own organization, money to spend in work that quickly and certainly will benefit himself. Within our own circles may we finance these preliminary steps in advancing our school, and thereby inspire the larger contributions that to our colleges and other institutions will come to us just as soon as we show ourselves deserving, and by our own giving, that we are responsible and capable stewards, well able to properly direct the spending of other people's money.

We are lothe to leave this recital of events on that second day of the meeting, for it was crowded full of interesting events. The Bureau of Homœopathy offered a program of much interest. The chairman, Dr. R. S. Faris of Richmond, demonstrated by his program the painstaking and capable effort which he put forth in its building. In the Bureau of

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the Practice of Medicine, many excellent papers were presented. Dr. A. H. Gordon, Chicago, read a paper on the diagnosis of gastric ulcer and allied conditions that in itself held much practical interest and produced a discussion that in its earnestness and instructive fulness was a distinctive event.

On Friday, came the bureaus, respectively, of Gynecology and Obstetrics, Dr. W. Scott Runnels, Ann Arbor, Chairman; Pediatrics, Dr. Cora Smith King, Washington, Chairman, and Surgery, Dr. Dean Smith, Daytona, Fla., Chairman.

In a communication elsewhere, the work of the latter bureaus will be taken up in detail, as space here does not permit. We may be allowed here space to mention the splendid work of the Richmond local committee, composed of Drs. Ralph Faris, C. W. Taber, J. H. Ryland, H. B. Baker and M. B. Coffman, in their arrangement of many details necessary to a successful meeting of the Association. Consider that these details are usually cared for by some score or two of workers, consider the thorough manner in which this small group of men handled them, and we can realize the devotion and other qualities which these men contributed to their work in entertaining the Southern Association.

And finally, along with many others, we left Richmond realizing that this annual meeting was a splendid success. The registrar's report is not at hand, and at a later date we must learn how many were present. But those in close touch with the sessions throughout know "who" were there, and the strength and enthusiasm alone that were ever present, testify impressively that the best of our people composed that attendance. Glad we are each year to see more and more men of the south at these gatherings, for we know well that no place of meeting can be chosen that is not far removed from where many of these are located. But as word goes back each year regarding the great interest of these annual gatherings, the effect is shown, as also their sincere desire to attend, by the larger number of them present at the next meeting. To our friends in the north and west who have done so much to aid the Association, and whom we believe find a growing attraction in these meetings, officials and members of the Association extend their sincere appreciation.

H. W. Stevenson, M.D.

1022 West Lafayette Avenue.

**Homœopathic Medical Society of the County of New York.**—The regular meeting of the Homœopathic Medical Society of the County of New York was held at the Academy of Medicine, 17 West 43rd St., Nov. 11, 1920, the meeting being called to order at 8.20 P. M. by the President, J. H. Fobes, M.D. Attendance 30. The minutes of the last meeting were read and approved.

On motion of Dr. Stearns, seconded by Dr. Danforth it was unanimously voted that Dr. Ferdinand Seege, 400 East 93rd Street, be re-instated to membership in the Society.

On motion of Dr. Dearborn, seconded by Dr. Carleton, Dr. M. K. Silberman, 748 Jackson Boulevard was nominated for Active Membership.

The Committee on Nominations, Addison S. Boyce, M.D., Chairman, presented the following candidates for officers for 1921, President, L. S. Loizeaux, M.D.; Vice-President, H. B. Safford, M.D.; Secretary, Charles Ver Nooy, M.D.; Treasurer, E. Wallace MacAdam, M.D.; Necrologist, P. C. Thomas, M.D.; Censors, G. G. Mack, M.D., D. B. Hill, M.D.; H. L. Neil, M.D., L. E. Hetrick, M.D. and H. E. Ayres, M.D.

Dr. Fobes announced the recent deaths of Drs. Virgil Thompson and M. Annette Pelham and appointed Drs. E. S. Franklin, J. W. Allen and L. B. Sherman as Memorial Committee to present resolutions for Dr.



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(The Hahnemannian Monthly)

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The Bureau of Clinical Medicine and Pathology and Preventive Medicine, G. F. Raynor, M.D. and E. D. Klots, M.D., Chairmen, were exceedingly fortunate in securing for an essayist, W. H. Watters, M.D. of the Department of Pathology and Bacteriology of the Boston University School of Medicine.

In a scientific, practical and comprehensive manner he spoke with logic and convincing force on the subject, "Problems in Syphilis, dealing with the subject relative to the pregnant woman, the new born child, old tertiary lesions and prognosis."

Discussion, Sprague Carleton, M.D.: K.I. does not cure syphilis. With reference to Wassermann tests made, very few of the laboratories tell you what method is used. We should ask and know for a fact what method is used, as it is of prime importance. With reference to prognosis, in the early stages, we may reasonably expect them to recover. I believe every case of syphilis is a danger point and calls for careful watching. I feel that something should be done with a syphilitic woman who is pregnant with a known syphilitic child. I have enjoyed Dr. Watters' paper very much and he has covered the field thoroughly.

General Discussion, L. L. Danforth, M.D.: Have enjoyed Dr. Watters' scholarly paper very much and can only say that I am surprised that he has had so few cases of abortion. He is to be congratulated.

E. D. Franklin, M.D.: Does the carrying and giving birth to a syphilitic child improve the condition of the mother? Is it possible in hereditary syphilis where the second generation has given birth to two children to have the first born shown no sign of syphilis, but the second one present unmistakable signs?

C. C. Boyle, M.D.: Gave history of syphilitic ulceration of the cornea in a married woman who had given birth to one dead child, ordered inunctions of mercury and two years later another child was born, perfectly normal in every way, and again two years later another perfect child was born, and Wassermann tests made by the Department of Health showed doubtful for the mother, but negative for the two children.

Elizabeth Jarnett, M.D.: What would you advise where father is positive and mother is negative, and has lost several children?

J. H. Fobes, M.D.: Syphilis and cancer may and often do coexist. My experience in neuro-syphilis is confined to eight cases, with satisfactory results. Have enjoyed Dr. Watters' paper very much.

G. F. Raynor, M.D.: Gave history in detail of two very interesting cases treated in the Metropolitan Hospital.

Dr. Abramowitz of the Department of Health, spoke in a complimentary way of Dr. Watters' paper and suggested the necessity of great caution in the manner of making Wassermann tests.

S. C. Roan, M.D.: The earlier the syphilitic begins treatment the better will be the results.

W. H. Dieffenbach, M.D.: How do you value colloid gold in your investigations?

W. H. Watters, M. D.: In closing the discussion, I would say, I cannot answer the question about the induction of abortion in those women who are known to be syphilitic. A macerated foetus in the uterus does not improve health of mother.

It is possible in hereditary syphilis where second generation has given birth to two children to have the first born show no signs of syphilis, whereas the second born may show unmistakable signs.



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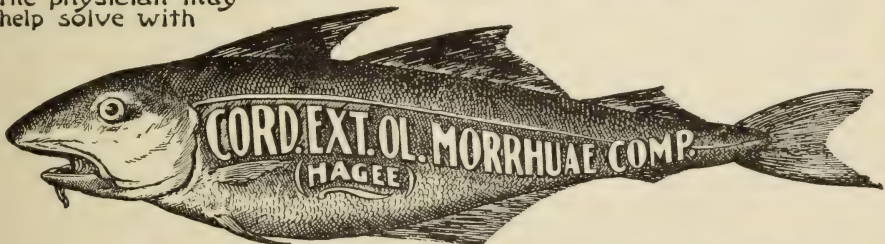
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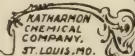
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On motion of Dr. Boyle, seconded by Dr. Raynor a most cordial vote of thanks was tendered Dr. Watters for his most timely, scholarly and edifying address.

Meeting adjourned at 10.15 P. M.

Charles Ver Nooy, M.D., Secretary.

**Homœopathic Medical Society of Philadelphia County.**—The regular monthly meeting of the Homœopathic Medical Society of the County of Philadelphia was held at Hahnemann College on Thursday evening November 11th, at 9 o'clock.

There were forty members present.

In the absence of the President, Dr. E. M. Howard the first Vice-President presided.

Dr. E. M. Gramm reported for the Legislative Committee and demonstrated the various forms which are necessary to procure from the Internal Revenue Department for the purchase of alcohol and dilutions.

Members of the Society are requested to send subscriptions of money to Dr. E. M. Gramm, chairman of the Benevolence Committee, to defray expenses of one of our members of the Class of 1869 who died in financial distress.

The resignation of Dr. Norman S. Betts who has received a permanent commission in the Medical Service of the United States Navy, was not accepted, but his name is to be continued upon the books of the Society as a member, because he has been a President of the Society and also has served for many years upon the Board of Trustees.

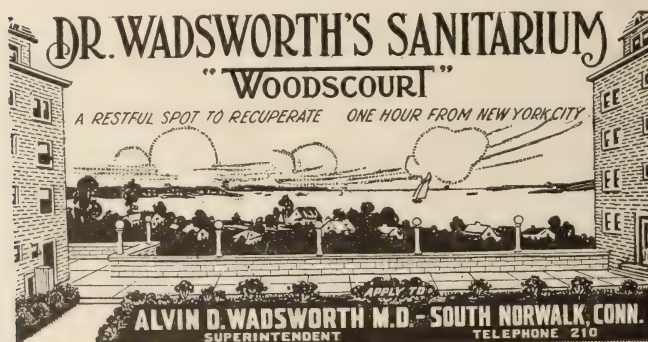
The scientific program of the evening was devoted to the discussion of the Medical and Surgical Treatment of Gastric Ulcer. Both papers presented were of unusual interest.

Dr. G. Harlan Wells read the first paper entitled, "The Medical Treatment of Gastric Ulcer."

Dr. A. B. Webster presented the Surgical side of the subject with a paper entitled "The Surgical Treatment of Gastric Ulcer."

The discussion was opened by Dr. H. M. Eberhard and Dr. H. L. Northrop.

Theodore K. Gramm, Secretary.



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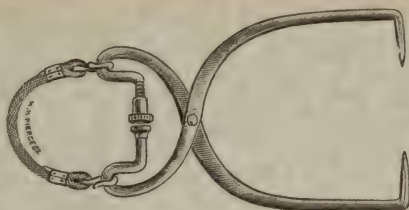
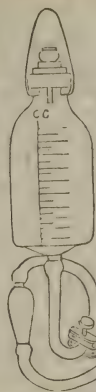


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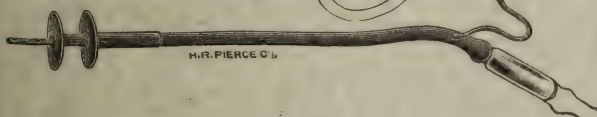
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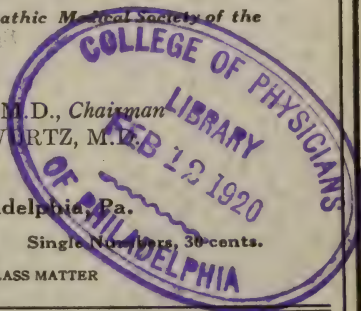
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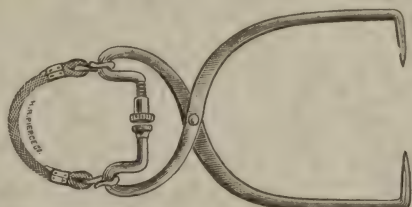
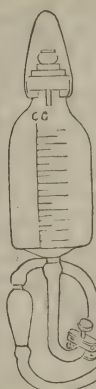


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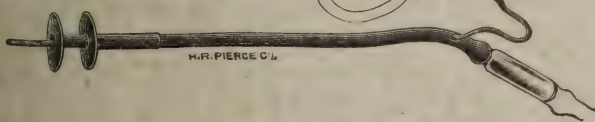
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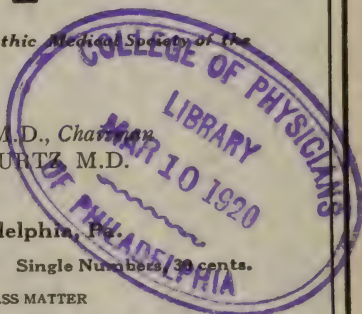
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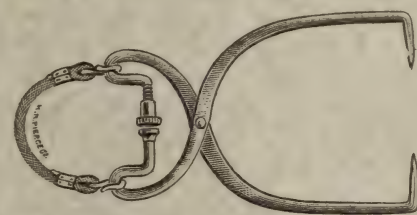
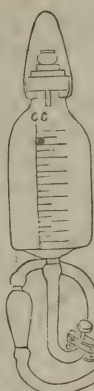
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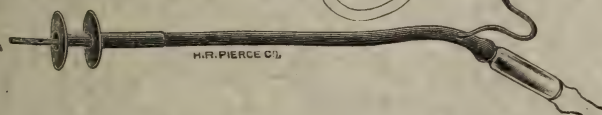
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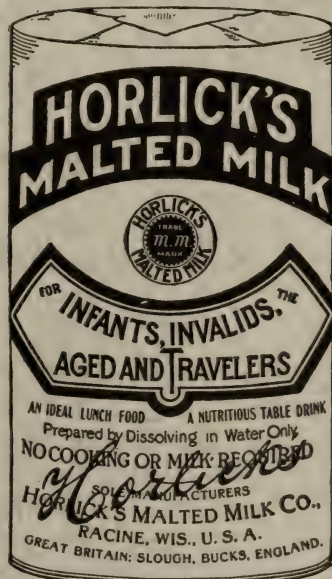
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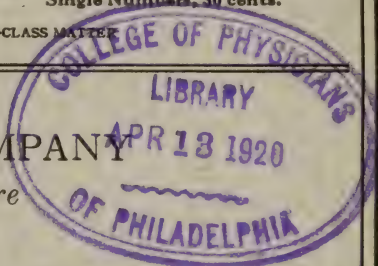
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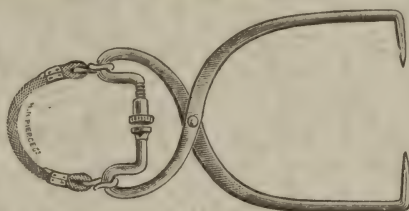
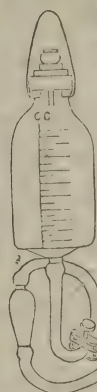
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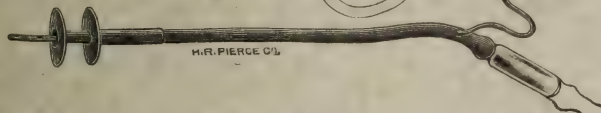
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No. 5

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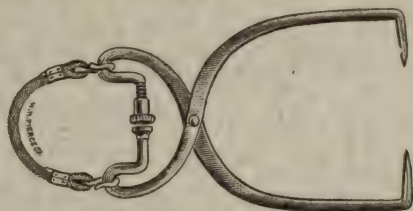
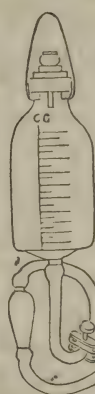
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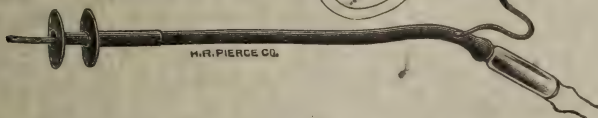
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VOL. LV

June, 1920

No. 6

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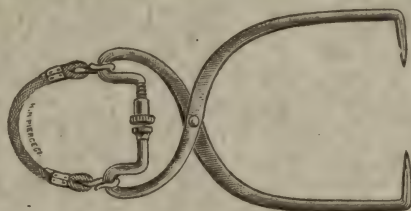
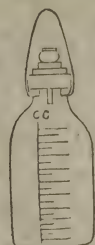


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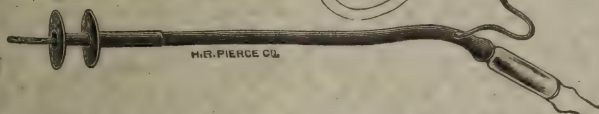
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VOL. LV July, 1920 No. 7

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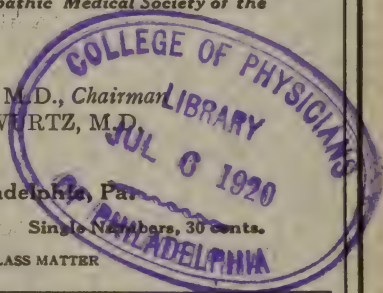
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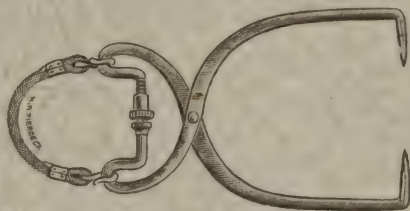
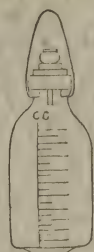
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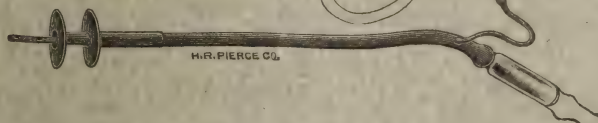
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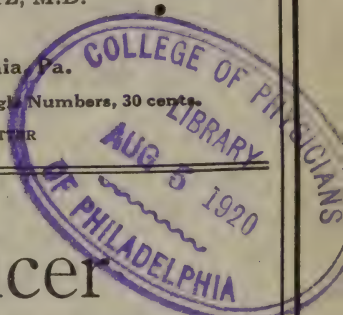
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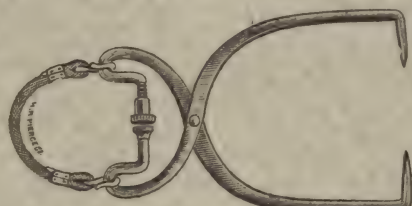
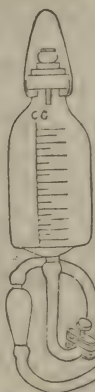
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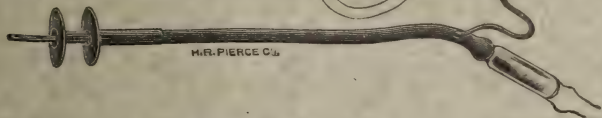
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VOL. LV

September, 1920

No. 9

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See this space in October number.

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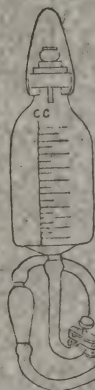
*Borden's*  
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Condensed Milk

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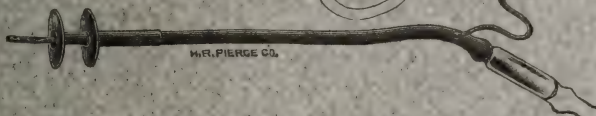
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THE ORIGINAL

The Preferred  
**X-RAY**  
Meal with  
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Is always clean, safe and reliable and protects your  
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entails its penalties—among them neurasthenia. The storm and stress of modern civilization exhaust the reserve force of the nervous system just as the suffering and hardships of war did

### *Hormotone*

proved of decided value in the treatment of neurasthenia following so-called shell-shock, and is just as efficacious in overcoming the nervous exhaustion induced more subtly, but just as surely, by the high-speed conditions of the Twentieth Century.

It tends to restore the

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essential to the maintenance of health and to the restoration of it in a run-down condition:

DOSE—One or two tablets three times daily before meals.

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VOL. LV

October, 1920

No. 10

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*Editorial Committee:* CLARENCE BARTLETT, M.D., *Chairman*  
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In one decade the duodenal tube has shown its great value in the diagnosis as well as in the treatment of the disease. Dr. Einhorn, in his new book, gives a full résumé of these accomplishments. The purpose of the book is twofold: (1) to acquaint the profession with the actual facts obtained through the instrumentality of the duodenal tube, presenting them in such a manner as to make them of clinical value; (2) to facilitate the work of others who may wish to enter this field of investigation. There are chapters on the duodenal tube and its congeners; the duodenal contents and their analysis; the diagnostic import of the tube; the tube as a therapeutic means—alimentation, instillation, lavage; other instruments for the pylorus, duodenum, and small intestine; practical uses of these instruments. There are 51 illustrations.

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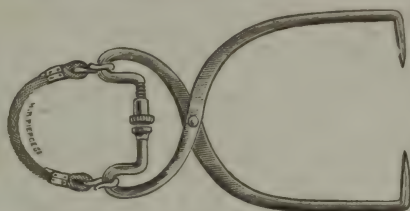
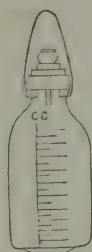
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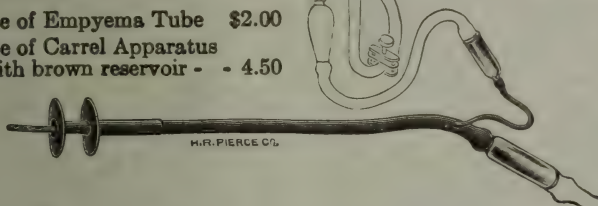
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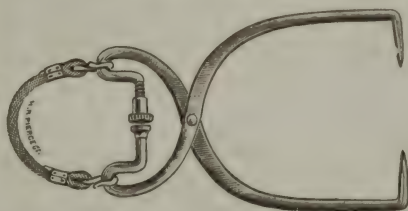
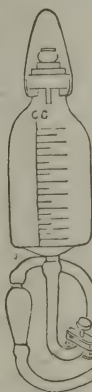
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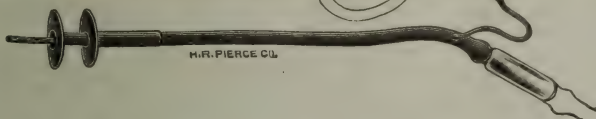
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VOL. LV

December, 1920

No. 12

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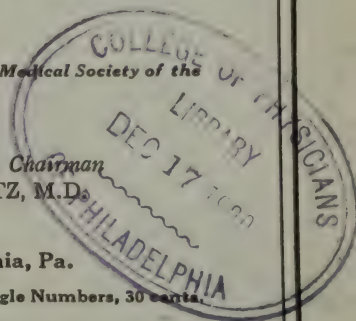
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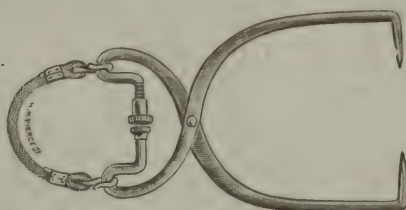
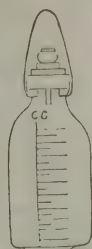
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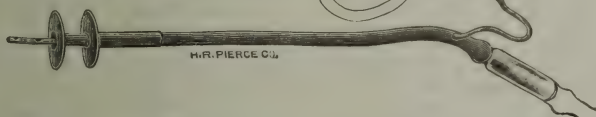
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